MEDICARE SUPPLEMENTAL INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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MEDICARE SUPPLEMENTAL INSURANCE

THURSDAY, MARCH 14, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:22 p.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 7, 2002
No. HL–14

CONTACT: (202) 225–3943

Johnson Announces Hearing on Medicare Supplemental Insurance

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on rationalizing Medicare supplemental insurance policies. **The hearing will take place on Thursday, March 14, 2002, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from the Administration. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Because Medicare's fee-for-service program has an antiquated and irrational cost-sharing structure, and fails to cover many essential items like prescription drugs, Medicare beneficiaries buy supplemental coverage to help pay for health care costs not covered by Medicare. Almost one-quarter (24 percent) of Medicare beneficiaries purchase this coverage as individuals through the private insurance "Medigap" market. In 1990, Congress created 10 standardized Medigap policies. All 10 plans are required to cover beneficiaries' coinsurance—some of the costs of Medicare services for which beneficiaries are responsible, such as 20 percent of the costs of a physician visit. Nine out of 10 of those policies, which comprise more than 90 percent of the Medigap market, are required to cover the Part A inpatient hospital deductible (currently $812), and the most popular Medigap policy covers both the Part A hospital deductible and the $100 Part B deductible for physician services.

Numerous studies have demonstrated that covering deductibles and coinsurance has led to markedly higher Medicare spending because beneficiaries become insensitive to costs. In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, 8 of the 10 plans are required to cover foreign travel insurance, while most beneficiaries never leave their home country. Because these standard policies are set by statute, however, insurers have not been able to modify their offerings to better serve seniors as the market has evolved.

In announcing the hearing, Chairman Johnson stated, "Given our desire to make improvements to Medicare this year, we must examine Medigap and how it should fill in the gaps of a revised fee-for-service program that includes a drug benefit. In addition, it's been 12 years since we looked at how effective the Medigap benefit package is in providing needed coverage to seniors. I am concerned that the current structure of Medigap, by providing first-dollar coverage, has produced excessive Medicare spending. I believe we can better design both Medicare and Medigap so that seniors and people with disabilities get the most for the health care dollars they spend."

FOCUS OF THE HEARING:

Thursday's hearing will focus on improving Medigap policies in Medicare. The Administration will present its proposals on Medigap reform.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to: hearingclerks@mail.house.gov along with a fax copy to (202) 225–2610, by the close of business, Thursday, March 28, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse unopened and unsearchable deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to hearingclerks@mail.house.gov, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

Note: All Committee advisories and news releases are available on the World Wide Web at http://waysandmeans.house.gov/.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call (202) 225–1721 or (202) 226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 13, 2002
No. HL–14–Revised

CONTACT: (202) 225–3943

Change in Time for Subcommittee Hearing on the Medicare Supplemental Insurance

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare Supplemental Insurance, scheduled for Thursday, March 14, 2002, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 2:15 p.m.**

All other details for the hearing remain the same. (See Subcommittee Advisory No. HL–14, dated March 7, 2002.)

Chairman JOHNSON. Good afternoon. I thank the panel for being with us and for your flexibility in adjusting to the rescheduling on rather late notice.

Two weeks ago, you may be aware that we held a hearing on Medicare's complex, confusing, irrational, and unfair physician payment formula. I said at that time that it clearly epitomizes why we can no longer delay modernizing Medicare. Well, today we look at Medigap and the deductible structure of Medicare. And one cannot escape the conclusion that again we cannot delay modernizing Medicare. No other program works like Medicare, which tends to raise the deductible the sicker you get.

Because Congress has not changed the law to modernize the program, 90 percent—9 out of 10 beneficiaries—feel compelled to carry supplemental insurance to fill in the holes that Medicare does not cover. Many receive retiree coverage through their former employers. The poor receive assistance through Medicaid. But more than one-quarter of beneficiaries purchase Medigap insurance themselves.

In 1990, Congress created 10 standardized Medigap policies to assist beneficiaries in choosing plans. And after 12 years, it is surely time to revisit the inadequacies and structure of these plans. All 10 Medigap plans are required to cover the coinsurance that beneficiaries must pay under Medicare; for example, the 20 percent of the cost of a physician visit. Nine out of 10 of these plans are required to cover the part A in-patient hospital deductible, which is currently $812.

The most popular Medigap policy covers both the part A hospital deductible and the $100 part B deductible for physicians' services.

And 8 of the 10 policies are required to cover foreign travel insurance—just in case these beneficiaries travel to France, though many never leave their home States. At the same time, only the three most expensive Medigap policies cover prescription drugs, through prescription drugs are seniors' most pressing need.

Numerous studies have demonstrated that Medigap's first-dollar coverage of medical services has encouraged inappropriate and often unnecessary care. Medicare spending rises because items and services appear free. This pushes up premiums for all Medicare recipients and the overall cost of the program to taxpayers.

While Medigap benefits have declined, particularly those covering prescription drugs, premiums have continued to rise. From 1998 to 2000, average premiums rose 16 percent for plans without drug coverage, and more than twice as fast—37 percent—for plans with drug coverage.

In addition, premiums vary dramatically for identical plans in the same location. Weiss Ratings Incorporated analyzed Medigap premiums in 2001. A 65-year-old man living in Fort Myers, Florida, would pay about $3,600 for Plan "J" from Physicians Mutual Insurance Co., but only $2,700 with United Health Insurance through AARP. That is nearly a $1,000 less for the same policy in the same location. The same gentleman living in Las Vegas would spend about $1,500 for Plan "C" with United American Insurance Company, but about half that amount—$778—with the USAA Life Insurance Co. for the same policy.

Much has changed in health care and health insurance over the past 12 years; but Medigap insurers have been unable to modify their plans in response to these market changes, because the 10 standard Medigap policies are set by statute.

I believe that we can better design both Medicare fee-for-service benefits and Medigap policies, so that seniors and persons with disabilities get the most for the health care dollars they spend and have access to the quality of care they deserve.

It is my great pleasure to welcome Bobby Jindal, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (HHS). I met Bobby when he was executive director of the bipartisan Medicare Commission. I am going to yield to my colleague to introduce him at a little greater length. Mr. McCrery.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairman, Subcommittee on Health

Good morning. Two weeks ago, we held a hearing on Medicare's complex, confusing, and totally irrational payment formula for physician services. I made the statement that it clearly epitomized why we can wait no longer to modernize Medicare.

After examining Medicare fee-for-service program's complex and irrational cost-sharing structure, I come to the same conclusion. Why would we charge seniors two different deductibles, and make the deductible for in-patient hospitalization—when a patient is least price sensitive—eight times higher than the outpatient deductible, when health care is arguably more discretionary? And why would we impose new cost-sharing on a patient who has been lying on her back in a hospital bed for two months? While most private health plans provide catastrophic protection for their enrollees, why does Medicare expose the sickest patients to unlimited cost-sharing? Similarly, while private plans integrated outpatient prescription drug coverage

years ago because it simply made sense, why does Medicare lack a prescription drug benefit?

The answer, of course, is that Congress has not changed the law to modernize the Medicare program. As a result, 90 percent—that's right, 9 out of 10 beneficiaries—feel compelled to carry supplemental insurance to fill in the holes that Medicare does not cover. Many receive retiree coverage through their former employer. The poor receive assistance through Medicaid. But more than one-quarter of beneficiaries purchase Medigap insurance themselves.

In 1990, Congress created 10 standardized Medigap policies to assist beneficiaries in choosing plans. After 12 years, it's time to re-visit the adequacy and structure of these plans. All 10 Medigap plans are required to cover the coinsurance that beneficiaries must pay under Medicare, for example, the 20 percent of the costs of a physician visit. Nine out of 10 of these plans are required to cover the Part A inpatient hospital deductible, which is currently $812. The most popular Medigap policy covers both the Part A hospital deductible and the $100 Part B deductible for physician services. And 8 of the 10 policies are required to cover foreign travel insurance, just in case these beneficiaries travel to France, though many never leave their home state! At the same time, only the three most expensive Medigap policies cover prescription drugs, though prescription drugs are seniors' most pressing need.

Numerous studies have demonstrated that Medigap's first dollar coverage of medical services has resulted in excessive Medicare spending because items and services appear free to beneficiaries. This higher utilization drives up costs for everyone—premiums of Medicare beneficiaries without Medigap coverage and costs to taxpayers. In addition, the prescription drug coverage mandated in Medigap is wholly inadequate.

Yet Medigap premiums continue to rise. From 1998 to 2000, average premiums rose 16 percent for plans without drug coverage, and more than twice as fast, 37 percent, for plans with drug coverage. In addition, premiums vary dramatically for identical plans in the same location. Weiss Ratings, Inc. analyzed Medigap premiums in 2001. A 65-year-old man living in Ft. Myers, Florida would pay about $3,600 for Plan J from Physicians Mutual Insurance Company, but only $2,700 with United Healthcare Insurance Company through AARP. That's nearly $1,000 less for the same policy in the same location! The same gentleman living in Las Vegas would spend about $1,500 for Plan C with United American Insurance Company, but about half that amount—$778 B with the USAA Life Insurance Company for the same policy.

Much has changed in health care and health insurance over the past 12 years. But Medigap insurers have been unable to modify their offerings in response to these market changes because the 10 standard Medigap policies are set by statute. I believe that we can better design both Medicare fee-for-service benefits and Medigap policies so that seniors and persons with disabilities get the most for the health care dollars they spend.

It is my pleasure to introduce Bobby Jindal, Assistant Secretary of Health and Human Services for Planning and Evaluation. I met Bobby when he was Executive Director of the Bipartisan Medicare Commission. He will present the Administration's proposal to add two new Medigap policies. The General Accounting Office will testify about the effects of first dollar coverage and potential reforms to Medigap coverage. Finally, we will hear from a representative of Medigap insurers and consumers about their ideas on reforming Medigap policies.

Mr. MCCRERY. Thank you, Madam Chair. It is my pleasure to introduce Bobby Jindal, who is from Louisiana and is well known throughout our State as being one of the special people who are very gifted, but who nonetheless choose to use those gifts in the service of the public. And he is doing so once again, as Assistant Secretary of Planning and Evaluation for HHS. So welcome, Bobby. We look forward to hearing your testimony.

Chairman JOHNSON. And before the panel begins, I would like to yield to my colleague and friend, Mr. Stark, for as long as his voice can bear.

Mr. STARK. Thank you, Madam Chair, and the distance between us today is just to keep you healthy.

Chairman JOHNSON. Without objection.

Mr. STARK. I hope that Mr. Jindal will be more candid in his remarks than the written testimony, which really does not describe the plan. It describes a kind of an outline of a plan. And the problem is that we cannot deal in outlines.

I happen to be the author of the current Medigap insurance regulations, and they were always intended to be changed from time to time to meet current conditions. And I want to thank the Chair for beginning this process.

I did find that, without an Administration plan as put out in their testimony, that the Congressional Budget Office (CBO), however, came up with a billion dollar savings over 10 years. And they said that they assumed there would be a $1,000 catastrophic cap, and that the catastrophic level for drug coverage would be $3,500, and that such a policy would cost beneficiaries $470 a month, and that only about 160,000 beneficiaries would purchase the policy.

Now, there may be assumptions that the Administration has used that are different from that, and it certainly would be good for us to know that. Because if we are going to do this, if the plans will save us some money by eliminating first dollar, we cannot force the public to buy them. We had better create something that will be attractive to them. And that seems to be a different approach than trying to restrain hospitals or doctors or pharmaceutical companies.

We have to, on the one hand, offer the public something that will be useful to them; and we have to deal in the dollars and pennies, because that is what our seniors deal in. So it would be helpful, before we go much further after today's hearing, if the Administration would care to share with us a plan. I do not think it is enough to just say, "Here is an outline," and we should write it. I think it is fair, if they have something in mind, that they detail it. Because we are going to be dealing with nickels and dimes. I mean, changing the premium a little will make a big difference; changing the co-pays will make a big difference. And it will make a big difference to seniors.

And it is not partisan. It is just how you want to design a benefit, and how much money there is going to be at the end of the day to pay the benefits or collect. And there is no sense—this is not anything that the Taliban can use to harm us. None of this information needs to be kept secret. It has nothing to do with invading Iraq. It just has to do with making seniors like me have better health insurance at something we can afford.

So I hope we can get down to the details quickly. And I would like to join in the process and support the Chair in finding some additional benefit structures. And I would hope that—and this will be the last words you will hear from me—that I could get my Republican colleagues to consider the possibility of a Federal plan.

We have been told—and I am not sure whether it was by CBO or the U.S. General Accounting Office (GAO)—that we would save 20 percent over commercial programs if we offered it and let the Centers for Medicare and Medicaid Services (CMS) run it. It would seem to me fair, with the proliferation of plans, that we could offer a Federal plan as one of the options. And if it is anything as big as 20 percent, it might be something we should at least examine.

And I thank you again for the hearing, and I look forward to hearing the testimony.

Chairman JOHNSON. I thank you. I would like to recognize the Honorable Mr. Jindal.

STATEMENT OF THE HON. BOBBY JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. JINDAL. Thank you, Chairman Johnson, Representative Stark, Representative McCrery, Representative Crane, distinguished Subcommittee Members.

I do look forward to talking to you about the details that are in the fact sheet as well as in the testimony. But I also want to first thank you for inviting me to discuss the important issue of Medicare supplemental insurance, commonly referred to as "Medigap," and to share with you the Administration's views about, and proposals to strengthen, this critical complement to the Medicare fee-for-service program. We do have details. We do have specific proposals. And I look forward to talking about those, both in response to your questions, and also as part of my testimony.

Clearly, as the Chairman and others have indicated, because of the major gaps in the benefit package in the current fee-for-service program, Medigap is an essential part of the Medicare benefits coverage for millions of our Nation's elderly and disabled. The Administration, however, also shares your concern regarding the rapid increases in Medigap premiums in recent years. Most seniors now pay more for Medigap than they pay in Medicare premiums. We also agree that, working together, we can better design both Medicare and Medigap so that seniors and people with disabilities can get more affordable coverage and get the most of their health care dollars that they spend.

As you know, the President has put forward a detailed framework for strengthening Medicare that would address the many threats to its ability to give seniors the health security they need. Medicare's lack of prescription drug coverage is only one example of the ways in which the programs lag behind.

The Administration also believes that Medicare should provide better coverage for preventive care and serious illness. Medicare's statutory benefits have enormous gaps, and its cost-sharing requirements can add up quickly. For example, beneficiaries who require $25,000 or more in care are typically responsible for about $5,000 in deductibles and copayments. Yet Medicare provides no stop-loss protection, and this is something the Administration believes should change.

As part of legislation to improve Medicare's existing coverage, it is also important to develop new Medigap options that better meet beneficiary needs and provide more affordable premiums. Clearly, the existing set of options, which require beneficiaries to purchase first-dollar coverage for hospitalizations and even basic services like doctor's visits before they can obtain any drug coverage at all, has become outdated.

Yet giving seniors the option of a better benefit package, including prescription drugs, and more affordable Medigap plans to go along with it, will take years to implement. So we have also pro-

posed that two new Medigap plans be added to improve beneficiaries' options quickly. These options would include valuable prescription drug coverage, protection against high out-of-pocket costs, and coverage of most of Medicare's cost sharing—all at a significantly lower price than the current Medigap options that already include prescription drugs.

While we are obviously willing to work with this Committee, with Congress, and with other interested parties, on the details of these initiatives, we believe that providing better short-term options for seniors to get more affordable drug coverage is a critical priority. In addition, these options would also generate modest savings for Medicare, as well as savings for beneficiaries.

Before I provide these additional details about our proposals, I would like to briefly review the key features and the problems with Medigap coverage today. As the Chair has already noted, one of the main reasons why seniors—nearly all seniors; over 90 percent of them—have some form of supplemental coverage is the fact that Medicare does not provide adequate protection against the cost of serious illness. As you know, the deductible for each hospital spell now exceeds $800, and will grow rapidly. And in addition to the hospital deductible and co-payment, eventually Medicare coverage can eventually run out altogether. This stands in stark contrast to private plans like the Blue Cross/Blue Shield option that is offered to all Federal employees, which has a single annual deductible and modest coinsurance for out-patient care, and provides much better coverage for hospitalizations.

And of course, not all beneficiaries get their supplemental insurance through Medigap. Those who are eligible often receive this coverage through Medicaid or their former employer. Others are able to lower their cost-sharing through joining a Medicare+Choice plan. It is important to recognize that, despite the changes in Medicare+Choice benefits, these plans still often provide a better deal for seniors than fee-for-service Medicare plus an increasingly costly Medigap policy.

Seniors face important problems in getting the coverage they need. And the written testimony certainly has more details about the antiquated benefit design and about the facts of first-dollar coverage. You have heard estimates not only from the actuary, but from GAO, from CBO, and others, that this increases utilization by at least 23 percent. I think it is particularly interesting to note that when you compare it to the cost-sharing coverage enjoyed by those with employer coverage, even there you have got a significant increase in utilization and spending by those with first-dollar coverage. According to the GAO and others, even modest changes in first-dollar coverage would lead to significantly lower Medicare costs, and in turn lower Medigap premiums.

And then finally, fourth, the issue of rising premiums: And again, I think you will hear more later—and it is in the written testimony—about the rapid increase both in Medigap plans that offer prescription drugs, but also for Medigap plans that do not offer prescription drugs.

Clearly, addressing these problems requires a comprehensive approach. That is why the President has outlined a comprehensive approach to strengthening Medicare which includes changes in cost

sharing. Again, I refer you to the testimony for more details about the President's plan. I know that you have heard about that before.

Let me just close by briefly mentioning that what the President has proposed will immediately add two new Medigap options. And again, the details are in your fact sheet. They are also covered in the testimony. One plan would cover 75 percent of current cost-sharing, without a drug benefit, similar to the ones that are offered today in Medigap. The second plan would offer coverage for additional drug expenses, like that in Plan "J," but would also have a higher stop-loss limit, and would cover 50 percent of Medicare's cost-sharing.

Both of these options would be much more affordable than current Medigap policies. Our actuaries said their premiums would be at least $500 lower. They would also reduce cost-sharing for beneficiaries, and provide much better protection against high cost.

Let me close by noting that up to one and a half million beneficiaries would choose these policies, almost half of whom would not have had drug coverage right now. So in addition to lowering costs for the program and providing better coverage and better options for seniors, we can also provide drug coverage to 700,000 seniors who do not have this coverage today. And this estimate may be a conservative one, based on surveys done by other groups.

Let me close by saying we are open to working with this Committee, other Members, and key stakeholders, going forward on the details. What is important to note is the current structure, with its emphasis on first-dollar coverage, does make prescription drug coverage much less affordable and much less accessible to seniors. We look forward to working with you to increase the accessibility and affordability of drug coverage, first, in the short term, through Medigap reforms, but in the long term, through the President's framework for improving the overall Medicare program. Thank you, Mr. Chairman, for letting me come and address the Committee.

[The prepared statement of Mr. Jindal follows:]

Statement of the Hon. Bobby Jindal, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

Chairman Johnson, Representative Stark, distinguished Subcommittee members, thank you for inviting me to discuss the issue of Medicare supplemental insurance, commonly referred to as Medigap, and to share with you the Administration's views about—and proposals to strengthen—this critical complement to the Medicare fee-for-service program. Clearly, because of the major gaps in the benefit package in the fee-for-service program, Medigap is an essential part of Medicare coverage for millions of our nation's elderly and disabled. The Administration shares your concern regarding the rapid increases in Medigap premiums in recent years: most seniors now pay much more for Medigap than they pay in Medicare premiums. We also agree that we can better design both Medicare and Medigap so that seniors and people with disabilities can get more affordable coverage, and get the most for the health care dollars they spend.

As you know, the President has put forward a framework for strengthening Medicare that would address the many threats to its ability to give seniors the health security they need. Medicare's lack of prescription drug coverage is only one example of the ways in which the program has lagged behind. The Administration also believes that Medicare should provide better coverage for preventive care and serious illness. Medicare's statutory benefits have enormous gaps, and its cost-sharing requirements can add up quickly. Beneficiaries who require $25,000 or more in care are typically responsible for about $5,000 in deductibles and co-payments. Yet Medicare provides no stop-loss protection—something the Administration believes should change.

As past of legislation to improve Medicare's existing coverage, it is also important to develop new Medigap options that better meet beneficiary needs and provide more affordable premiums. Clearly the existing set of options, which require beneficiaries to purchase "first-dollar" coverage for hospitalizations and even basic services like doctor's visits before they can obtain any drug coverage, has become outdated. Yet giving seniors the option of a better benefit package, including prescription drugs, and more affordable Medigap plans to go along with it will take several years to implement. So we have also proposed that two new Medigap plans be added to improve beneficiaries' options quickly. These options would include valuable prescription drug coverage, protection against high out-of-pocket costs, and coverage of most of Medicare's cost-sharing—all at a significantly lower price than the current Medigap options that include prescription drugs. While we are obviously willing to work with Congress and other interested parties on the details of these initiatives, we believe that providing better short-term options for seniors to get more affordable drug coverage is a critical priority. In addition, these options would generate modest savings for Medicare as well as savings for beneficiaries.

BACKGROUND

Before I provide additional details about our proposals, I would like to briefly review the key features of—and problems with—Medigap coverage today. One of the main reasons why nearly all seniors in the fee-for-service (government) plan have supplemental insurance is that Medicare does not provide adequate protection against the costs of serious illness. As you know, the deductible for each hospital spell now exceeds $800 and will grow rapidly. Moreover, Medicare beneficiaries who require long hospital stays are exposed to daily co-payments that run into the hundreds of dollars—and Medicare coverage can eventually run out altogether. This stands in stark contrast to private plans like the Blue Cross/Blue Shield plan offered to Federal employees, which has a single annual deductible and modest coinsurance for outpatient care but provides much better coverage for hospitalizations. Not surprisingly, the Coalition to Preserve Choice for Seniors (which consists of several Medigap insurers) recently found that coverage of hospital expenses not paid by Medicare is the Medigap benefit that seniors value most.

Of course, not all beneficiaries get their supplemental insurance through Medigap. Those who are eligible often obtain this coverage through Medicaid or their former employer. Many have been able to lower their co-payments and deductibles by joining a Medicare+Choice plan. It is important to recognize that, despite the changes in Medicare+Choice benefits that have resulted from years of consistently inadequate payment updates, these plans still provide a better deal for seniors than fee-for-service Medicare plus an increasingly costly Medigap policy. That is why the Administration places a high priority on ensuring that these private plan options remain available for beneficiaries.

But the focus of our discussion today is on the roughly 10 million beneficiaries who have to purchase their own Medigap policy. The designs of these policies were standardized in 1990 and have scarcely been updated since. As a result, these seniors face important problems in getting the coverage they need:

- *Antiquated benefit design.* The 1990 reforms created 10 standard Medigap plans, but three specific designs account for about three-fourths of the enrollment in these standardized plans. This concentration of enrollment suggests that the other available plans are not providing the range of options that beneficiaries need. What is more, Medigap drug coverage can be purchased only in combination with first-dollar coverage for other services. As a result, the added premiums for these policies can be so high that they greatly limit the value of the benefit—if these policies are available at all. Not surprisingly, less than 10 percent of those who purchase a standardized plan buy one that covers drugs. In effect, it is easier for seniors to get coverage for a foreign travel emergency than it is to get drug coverage from Medigap.
- *First-dollar coverage.* All of the standard Medigap plans pay the up-front costs of care for beneficiaries, often including the first dollar spent. Research has demonstrated that first-dollar coverage results in increased utilization and higher costs without providing clear health benefits. The independent Office of the Actuary at CMS estimates that service use is 23 percent higher for beneficiaries with Medigap than for those without supplemental insurance.* Medicare pays most of these costs, but first-dollar coverage also leads to higher Medicare and Medigap premiums. Indeed, the added cost of a Medigap policy

*Other independent analysts have reached similar conclusions; see Hogan (Testimony before the Subcommittee on Health of the House Committee on Ways and Means, May 9, 2001) and Physician Payment Review Commission (1997).

that covers the $100 Part B deductible often exceeds $100—so seniors who purchase these policies are merely "dollar trading." According to GAO and others, even modest changes in first-dollar coverage would lead to significantly lower Medicare costs, and in turn, Medigap costs. Additionally, almost all private insurance plans avoid first-dollar coverage and instead use reasonable co-payments. Private plan enrollees have some limited out-of-pocket costs to help encourage appropriate use of services, and they benefit from much lower insurance premiums. As a result, Medicare spending for those with supplemental coverage through their employer is about 10% less than for those with individual Medigap policies.

• *Rising premiums.* The result of these problems can be seen in high and rising premiums. In 1998, the average senior was actually spending more on supplemental insurance premiums than on prescription drugs. According to Weiss Ratings, the cost of Medigap policies that provide drug coverage has grown rapidly since then—by 17 to 34 percent in 2000 alone. Premiums for Medigap policies that do not cover drugs did not rise quite as fast in 2000 but over the past three years have increased 25 to 45 percent.

IMPROVING MEDICARE AND MEDIGAP FOR THE FUTURE

Clearly, addressing these problems requires a comprehensive approach. That is why the President worked with Members of Congress from both parties to develop a framework for strengthening and improving Medicare. It includes giving all seniors the option of subsidized prescription drug coverage. It includes giving seniors better options to reduce their costs in a private plan. And it includes giving seniors the option of keeping the coverage they have now or choosing an improved benefit package with better coverage for preventive care and serious illness as part of a modernized fee-for-service plan. In specific:

• Medicare's preventive benefits should have zero co-payments and should be excluded from the deductible.

• Medicare's traditional plan should have a single indexed deductible for Parts A and B to provide better protection from high expenses for all types of health care.

• Medicare should provide better coverage for serious illnesses, through lower co-payments for hospitalizations, better coverage for very long acute hospital stays, simplified cost sharing for skilled nursing facility stays, and true stop-loss protection against very high expenses for Medicare-covered services.

• These changes should not reduce the overall value of Medicare's existing benefits.

These improvements in Medicare's coverage will reduce the benefit gaps that Medigap must fill and will lower Medigap premiums. But the President's framework also includes updated and more affordable Medigap options for beneficiaries who choose the improved Medicare benefit package. These new options should begin by giving beneficiaries even better protection against high-costs—supplementing the stop-loss limit that would be added to Medicare. More generous policies could then reduce Medicare's deductibles and co-payments—but they should not be structured in such a way that seniors have to buy first dollar coverage for hospitalizations and doctor's visits before they can obtain drug coverage or supplement the Medicare drug benefit.

At the same time, the President strongly believes that beneficiaries who wish to keep their current benefits with no changes must be able to do so. Let me be clear: under the President's framework, seniors who are happy with their current Medigap policy would never have to change it.

Such restructuring will also take time. However, to provide more affordable Medigap options before the improved benefit package becomes available, and to improve the Medigap options available for seniors who prefer their current Medicare benefits, the Administration proposes the addition of two new Medigap plans to the existing ten standardized plans. We believe both of these new plans should cover all of the coinsurance for extended hospital says in the same way that the current Medigap plans do, but should not cover the Part B deductible. To give seniors a choice about how best to meet their needs:

• One plan would cover 75 percent of current cost-sharing and have a lower stop-loss limit whiie providing modest drug coverage that most beneficiaries would value. The drug benefit would have a $250 deductible and cover half of the next $2,500 in drug spending (as in the current Medigap plans H and I).

• The other would provide coverage for additional drug expenses—like the current plan J—but have a higher stop-loss limit and cover 50 percent of Medicare's cost-sharing.

Both of these options would be considerably more affordable that the current Medigap policies that cover drugs. They would substantially reduce cost-sharing for beneficiaries and provide much better protection against high costs. They would also provide needed options for beneficiaries who want lower premiums but have not chosen to enroll in one of the two high-deductible Medigap policies—giving beneficiaries a choice between "all or nothing." And they would increase the number of seniors with drug coverage. If we provide a one-time opt-in for current beneficiaries, we estimate that up to 1.5 million beneficiaries would choose these new policies once they are available—and that nearly half of these enrollees would be beneficiaries who do not have drug coverage now. This could even be a conservative estimate; the Coalition to Preserve Choice for Seniors found that one-third of Medigap policy holders would favor a proposal that included a modest deductible and some payments for doctor visits and hospital stays—even without the offer of drug coverage. Moreover, we can achieve this significant increase in drug coverage among seniors right away, not several years down the road, while saving money for beneficiaries and the Medicare program.

Let me reiterate that we are quite open to working with this Committee, other Members, and key stakeholders going forward. For example, it could be that a nominal co-pay for doctor's visits would work better than a fixed percentage or that the drug benefit designed could be improved. But, as with our other Medicare proposals, we want to act now. The idea of making updated Medigap plans available has long had bipartisan support. For example, President Clinton proposed to update Medigap with a new supplemental coverage option that included reasonable limits on cost sharing. The new plans we are proposing would also generate modest budgetary savings—at least $1.3 billion over 10 years—since they would not provide first-dollar coverage. But the primary reason we support them is that they provide another means for seniors to obtain more affordable drug coverage quickly. I look forward to answering your questions.

Chairman JOHNSON. Thank you very much. Mr. Scanlon, a pleasure to have you before the Subcommittee again.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Madam Chairwoman and Members of the Subcommittee. I am very pleased to be here today as the Subcommittee considers the issue of Medicare supplemental benefits. And I think there is a great deal of agreement between the facts that we have examined about these policies and what you have heard from Mr. Jindal and what was mentioned in your opening statements.

There is no issue that Medicare beneficiaries are in need of supplementary coverage, given the structure of the program. We have heard a lot over the past several years about the lack of prescription drug coverage. And that is certainly understandable, given the importance that pharmaceuticals have, the role that they play in terms of being effective treatments for a variety of conditions, and because of the rapid rise in drug costs.

I think it is also important that this Subcommittee last year brought a great deal of attention to the fact that Medicare is not a genuine insurance program; that you are not protected against catastrophe; there is no stop-loss coverage; that Medicare cost sharing can leave you vulnerable for considerable expenditures. In fact, close to three and a half million beneficiaries in 1997 were liable for more than $2,000, and approximately 750,000 of them were liable for more than $5,000 that year.

Given that, it is not surprising that people turn to supplementary coverage. And given that not all beneficiaries are eligible

for either employer-based coverage, Medicare+Choice, or Medicaid, Medigap is a very popular option. As you indicated, about 25 percent of beneficiaries have such policies.

But the policies we have today are problematic by themselves. They are, as you have heard and have indicated, expensive. The expense, while high at the national level, varies greatly by geography; so that people in certain areas spend much, much more than the national level for a policy, and spend even more depending upon the insurer that they choose.

Policies are expensive in part because they are marketed individually, as opposed to being sold to groups. And one of the results of that is that about 20 percent of policy premiums go to administrative costs. The policies are expensive also because of the design of those policies, which is dictated by Omnibus Budget Reconciliation Act 1990 (OBRA '90).

In creating the 10 standardized packages, we have essentially eliminated most of Medicare cost sharing, as you have indicated. And given that so many elderly use at least some medical care during the course of the year, policies essentially function like a prepayment arrangement, rather than as insurance. With insurance, you would expect that only a fraction of policy holders are likely to incur a loss and therefore receive a benefit, and premiums can be correspondingly lower. However, when everybody is virtually going to receive a benefit, then premiums have to be much higher.

Medigap premiums are also higher because of that structure, in terms of eliminating the cost sharing, because it leads beneficiaries to use more services. One study that we quoted in our testimony indicates that Medigap policy holders use 28 percent more services than beneficiaries without supplemental coverage. Obviously, this does not only add to the cost of a Medigap policy; it adds to the cost of the Medicare program.

The other major drawback with Medigap policies is the inadequate prescription drug coverage. With available coverage, beneficiaries must pay over half their drug expenses, and have significant limits that do not provide catastrophic protection for extreme drug costs.

There are likely benefits from creating these standardized packages, or standardized plans, in the OBRA '90, given the abuses that were reported in the Medigap market before then. However, it does seem that it is now time to think about revisiting the design of these packages, and that new options would benefit both policy holders and the program.

The Administration's proposal seems to point in the right direction. Having new options involving catastrophic protection, having drug coverage, and reducing the amount of first-dollar coverage, we think are positive. Having not had the details before today, we could not look at them in detail, and would need to do so in order to comment on the merits of these proposals versus others. But I think it is important that we start to move toward making Medigap policies more like employer-based insurance. That is, to have some first-dollar cost sharing that encourages the prudent use of services; to structure cost sharing in a way that discretionary services have cost sharing, and less discretionary services may not; for instance, not to have cost sharing for hospitalizations which are

rarely discretionary. This type of policy is likely to moderate costs and to change use somewhat, but not too severely.

Studies have also shown that Medicare beneficiaries with employer-based insurance use 17 percent more services than beneficiaries without supplementary insurance. That compares to the 28 percent that I noted earlier.

We would be happy to work with this Subcommittee as you consider these options. And that completes my statement. I will be happy to answer any questions that you have.

[The prepared statement of Mr. Scanlon follows:]

Statement of William J. Scanlon, Director, Health Care Issues, U.S. General Accounting Office

Madam Chairwoman and Members of the Subcommittee:

I am pleased to be here today as you consider the role of "Medigap" policies in supplementing the Medicare benefit. Medicare provides valuable and extensive coverage for the health care needs of 40 million elderly and disabled beneficiaries. Nevertheless, recent discussions have underscored the significant gaps that leave some beneficiaries vulnerable to sizeable financial burdens from out-of-pocket costs. Most beneficiaries have additional supplemental coverage that helps to fill Medicare's coverage gaps and pay some out-of-pocket expenses. Privately purchased Medigap policies are an important source of this supplemental coverage because they are widely available to beneficiaries. The other sources—employer-sponsored policies, Medicare+Choice plans, and Medicaid programs—are not available to all beneficiaries. However, concerns exist that Medigap policies can be expensive and may undermine the legitimate role of cost-sharing in a health insurance plan—that is, to encourage the cost-effective use of services. Moreover, due to statutory restrictions, these policies provide only limited prescription drug coverage, leaving an important gap in beneficiary protection against high health care expenses.

In this context, the president has proposed adding 2 new types of Medigap plans to the existing 10 standard plan types.[1] The new plans would provide protection against catastrophic expenses for Medicare-covered services and would include different levels of prescription drug coverage. To help keep premiums affordable, the new plans would also require beneficiary cost-sharing. At this point, detailed specifications for these plans are not available.

To assist the subcommittee as it considers ways to improve protections for beneficiaries, my remarks today focus on the design of Medicare's benefit package and the role that Medigap plays in providing supplemental coverage. Specifically, I will discuss (1) beneficiaries' potential financial liability under Medicare's current benefit structure and cost-sharing requirements, (2) the cost of Medigap policies and the extent to which they provide additional coverage, and (3) concerns that Medigap's so-called "first dollar" coverage—its coverage of Medicare's required deductibles and coinsurance—undermines the cost control incentives of Medicare's cost-sharing requirements. My comments are based on our prior and ongoing work on Medicare and Medigap as well as other published research.[2]

In summary, Medicare's benefit package and cost-sharing requirements leave beneficiaries liable for high out-of-pocket costs. As currently structured, Medicare provides no limit on out-of-pocket spending and no coverage for most outpatient prescription drugs—a component of medical care that is of growing importance in treatment and rapidly increasing in cost. Recent estimates suggest that about 45 percent of Medicare beneficiaries' health care costs are not covered.

Medigap policies help to fill in some of Medicare's gaps but also have shortcomings. They are often expensive. In 1999, premiums paid for Medigap policies averaged $1,300, with more than 20 percent going to administrative costs. Medigap plans typically cover Medicare's required deductibles, coinsurance, and copayments but do not fully protect beneficiaries from potentially significant out-of-pocket costs. Medigap policies offering prescription drug coverage can be inadequate because beneficiaries still pay most of the cost and the Medigap benefit is capped. In addition, Medigap's first-dollar coverage eliminates the effect Medicare's cost-sharing requirements could have to promote prudent use of services. The danger is that some

[1] Budget of the United States Government, Fiscal Year 2003 (Washington, D.C.: Government Printing Office, Feb. 4, 2002).

[2] U.S. General Accounting Office, Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs, GAO–01–941 (Washington, D.C.: July 31, 2001).

services may be overused, ultimately increasing costs for beneficiaries and the Medicare program.

Background

Individuals who are eligible for Medicare automatically receive Hospital Insurance (HI), known as part A, which helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Beneficiaries pay no premium for this coverage but are liable for required deductible, coinsurance, and copayment amounts. (See table 1.) Medicare-eligible beneficiaries may elect to purchase Supplementary Medical Insurance (SMI), known as part B, which helps pay for selected physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, currently $54 per month.[3] Beneficiaries are also responsible for part B deductibles and coinsurance.

TABLE 1: MEDICARE COVERAGE AND BENEFICIARY COST-SHARING, 2002

Part A Coverage	Copayments and deductibles
Inpatient hospital	For each benefit period: $812 deductible for up to 60 days [a] $203/day for days 61 through 90 $406/day for days 91 through 150 [b] All costs beyond 150 days
Skilled nursing facility	For each benefit period: Nothing for up to 20 days $101.50/day or less for days 21 through 100 All costs beyond 100 days
Home health	Nothing 20 percent of approved amount for durable medical equipment
Hospice	$5 or less for outpatient drugs 5 percent of approved amount for inpatient respite care
Blood	Cost of first 3 pints
Part B Coverage [c]	**Copayments and deductibles**
Physician and Medical	$100 deductible each year 20 percent of approved amount 50 percent of approved amount for mental health
Clinical laboratory	Nothing
Home health	Nothing 20 percent of approved amount for durable medical equipment
Outpatient hospital	Coinsurance or copayment varies according to service (after part B deductible)
Blood	Cost of first 3 pints 20 percent of approved amount (after part B deductible) for additional pints

[a] No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

[b] After the first 90 days of inpatient care, Medicare may help pay for an additional 60 days of inpatient care (days 91 through 150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

[c] No cost-sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer and flu and pneumonia vaccines.

Source: Centers for Medicare and Medicaid Services, ***Medicare & You 2002***. CMS–10050 (Baltimore: Sept. 2001).

Most Medicare beneficiaries have some type of supplemental coverage to help pay for Medicare cost-sharing requirements as well as for some services not covered by Medicare. They obtain this coverage either through employers, Medicare+Choice plans, state Medicaid programs, or Medigap policies sold by private insurers.

[3] The premium amount is adjusted each year so that expected premium revenues equal 25 percent of expected part B spending.

About one-third of Medicare's 40 million beneficiaries have employer-sponsored supplemental coverage. These plans, which typically include cost-sharing requirements, pay for some costs not covered by Medicare, such as shares of coinsurance and deductibles and the cost of prescription drugs. However, many beneficiaries do not have access to employer-sponsored coverage. A recent survey found that more than 70 percent of large employers with at least 500 employees did not offer these health benefits to Medicare-eligible retirees.[4] Small employers are even less likely to offer retiree health benefits.

Approximately 14 percent of Medicare beneficiaries are enrolled in Medicare+Choice plans, which include health maintenance organizations (HMO) and other private insurers who are paid a set amount each month to provide nearly all Medicare-covered services. Compared to Medicare's traditional fee-for-service program, HMOs typically offer lower cost-sharing requirements and additional benefits, including prescription drugs, in exchange for a restricted choice of providers. However, Medicare+Choice HMOs are not available in all parts of the country. In 2002, about 40 percent of all beneficiaries live in counties where there are no Medicare+Choice HMOs.

In 1997, about 17 percent of Medicare beneficiaries received assistance from Medicaid, the federal-state health financing program for low-income aged and disabled individuals. Depending upon state-defined eligibility policies, some of these low-income individuals are entitled to full Medicaid benefits (so called "dual eligibles"), which include coverage for certain services not available through Medicare, such as most outpatient prescription drugs. Under federal law, all Medicare beneficiaries with incomes below the federal poverty level are entitled to have their Medicare premiums and cost-sharing paid for by Medicaid. Similarly, Medicare beneficiaries with incomes slightly above the poverty level are eligible to have all or part of their Medicare premiums paid for by Medicaid.[5]

Medigap is the only supplemental coverage option available to all beneficiaries when they initially enroll in Medicare at age 65 or older. Medigap policies are offered by private insurance companies in accordance with state and federal insurance regulations. In 1999, more than 10 million individuals—about one-fourth of all beneficiaries—were covered by Medigap policies.[6] The Omnibus Budget Reconciliation Act of 1990 (OBRA) required that Medigap policies be standardized and allowed a maximum of 10 different benefit packages offering varying levels of supplemental coverage.[7] Policies sold in most states since July 31, 1992, are modeled on 1 of the 10 standardized packages, known as plans A through J. (See table 2.) Policies sold prior to this time were not required to comply with the standard benefit package requirements. The Balanced Budget Act of 1997 permitted insurers to offer high-deductible versions of the existing F and J plans.[8]

TABLE 2: BENEFITS COVERED BY STANDARDIZED MEDIGAP POLICIES

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan Fa	Plan G	Plan H	Plan I	Plan Ja
Coverage for: • Part A coinsurance • 365 additional hospital days during lifetime • Part B coinsurance • Blood	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X

[4] William M. Mercer, Incorporated, Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000 (New York, N.Y.: 2001).

[5] Many low-income Medicare beneficiaries who are eligible for Medicaid and other federal-state programs that provide assistance with premiums and cost-sharing requirements may not enroll, in part due to limited awareness of these programs and the administrative complexity of demonstrating eligibility. See U.S. General Accounting Office, Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment, GAO/HEHS–99–61 (Washington, D.C.: Apr. 9, 1999).

[6] The National Association of Insurance Commissioners reports that Medigap enrollment has declined from about 14 million in 1994.

[7] Pub. L. 101–508, § 4351, 104 Stat. 1388–30, 1388–127 (1990).

[8] Pub. L. No. 105–33, § 4032, 111 Stat. 251, 359 (1997).

TABLE 2: BENEFITS COVERED BY STANDARDIZED MEDIGAP POLICIES—Continued

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan Fa	Plan G	Plan H	Plan I	Plan Ja
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing[b]						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Outpatient prescription drugs								X[c]	X[c]	X[d]
Preventive medical care					X					X

Note: This chart does not apply in Massachusetts, Minnesota, and Wisconsin, where alternative standards for supplemental health policies exist.

[a] Plans F and J also have a high-deductible option ($1,620 in 2002) under which beneficiaries also pay deductibles for prescriptions ($250 per year for plan J) and foreign travel emergency ($250 per year for plans F and J).

[b] Some providers do not accept the Medicare rate as payment in full and "balance bill" beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payment rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.

[c] Plans H and I pay 50 percent of drug charges up to $1,250 per year and have $250 annual deductibles.

[d] Plan J pays 50 percent of drug charges up to $3,000 per year and has a $250 annual deductible.

Source: Health care Financing Administration, *2001 Guide to Health Insurance for People with Medicare*, HCFA–02110 (Baltimore: 2001).

Currently, Medicare beneficiaries aged 65 and older are guaranteed access to Medigap policies within 6 months of enrolling in part B, regardless of their health status.[9] Subsequent laws have added guarantees for certain other beneficiaries. Beneficiaries who enroll in a Medicare+Choice plan when first becoming eligible for Medicare at age 65 and then leave the plan within 1 year are also guaranteed access to any Medigap policy. Those who terminate their Medigap policies to join a Medicare+Choice plan can return to their previous policies or, if the original policies are not available, be guaranteed access to plans A, B, C, and F, none of which covers prescription drugs. Also, individuals whose employers eliminate retiree benefits or whose Medicare+Choice plans leave the program or stop serving their areas are guaranteed access to these four standardized Medigap policies.[10] Beneficiaries who do not meet any of these conditions may be denied coverage or be charged higher premiums.

Medicare's Cost-Sharing Requirements and Gaps in Prescription Drug Coverage Put Beneficiaries at Considerable Financial Risk

In Medicare, the lack of dollar limits on beneficiaries' cost-sharing obligations—deductibles, coinsurance, and copayments—puts beneficiaries with extensive health care needs at risk for very large expenses for Medicare-covered services. Similarly, Medicare's lack of coverage for certain services, especially most outpatient prescription drugs, can expose beneficiaries to substantial financial risk. The increasingly important role of pharmaceuticals in medical care and the continuing rapid increases in drug prices accentuate this risk.

Unlike most employer-sponsored plans for active workers, Medicare does not limit beneficiaries' cost-sharing liabilities, which can represent a significant share of their personal resources. In 2000, premiums, deductibles, coinsurance, and copayments that beneficiaries were required to pay for services that Medicare covers equaled an estimated 23 percent of total Medicare expenditures. For Medicare-covered services alone, beneficiaries who obtained services in 1998 had an average liability of $1,458,

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[9] 42 USC § 1395ss(s)(2)(A).

[10] These protections, which applied to beneficiaries aged 65 and older, were added by the Balanced Budget Act, Pub. L. 105–33, § 403,111 Stat. 251, 330. In addition to these federal protections, 21 states provided for additional Medigap protections in 2000.

consisting of $932 in Medicare cost-sharing in addition to the $526 in annual part B premiums for that year.

However, the burden of Medicare cost-sharing can be much higher for beneficiaries with extensive health care needs. In 1998, the most current year of available data on the distribution of these costs, about 3.4 million beneficiaries (11.5 percent of beneficiaries who obtained services) were liable for at least $2,000 for Medicare cost-sharing and part B premiums. Approximately 736,000 of these beneficiaries (2.5 percent) were liable for at least $5,000, and about 167,000 beneficiaries (0.6 percent) were liable for at least $10,000. In contrast, private employer-sponsored health plans for active workers in 2000 typically limited maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[11]

Furthermore, Medicare provides no coverage for certain health care services, such as most outpatient prescription drugs. These limitations put beneficiaries at additional risk of incurring potentially catastrophic expenses. Current estimates suggest that the combination of Medicare's cost-sharing requirements and limited benefits leaves about 45 percent of beneficiaries' health care costs uncovered. In 2000, the average beneficiary is estimated to have incurred about $3,100 in total out-of-pocket expenses for health care—an amount equal to about 22 percent of beneficiary income.[12]

The combination of Medicare cost-sharing and costs of uncovered services represents a much greater financial burden for some beneficiaries. For example, in 2000, elderly beneficiaries in poor health and with no Medicaid or supplemental insurance coverage are estimated to have spent 44 percent of their incomes on health care. Low-income single women over age 85 who are in poor health and not covered by Medicaid are estimated to have spent more than half (about 52 percent) of their incomes on health care services.[13] These percentages are expected to increase over time as Medicare premiums and costs for prescription drugs and other health care goods and services rise faster than incomes.

Current Medigap Policies Address Some Medicare Shortcomings But Are Expensive

The shortcomings in Medicare's benefit package underscore the importance of supplemental health insurance for program beneficiaries. More than one-fourth of beneficiaries have Medigap policies to fill Medicare coverage gaps, but these policies can be expensive and do not fully protect beneficiaries from catastrophic out-of-pocket expenses. Medigap policies that provide drug coverage offer only limited protection from prescription drug expenses because of high cost-sharing and low coverage caps. The extent to which the president's proposed plan types—which include catastrophic coverage protection, a prescription drug benefit, and beneficiary cost-sharing requirements—would address these shortcomings will depend on the details of the new policies.

Medigap Fills Some Needs

More than 10 million Medicare beneficiaries have Medigap policies to cover some potentially high costs that Medicare does not pay, including cost-sharing requirements, extended hospitalizations, and some prescription drug expenses. By selecting from among a group of standardized plans, beneficiaries can match their coverage needs and financial resources with plan coverage. Medigap policies are widely available to beneficiaries, including those who are not eligible for, or do not have access to, other insurance to supplement Medicare, such as Medicaid or employer-sponsored retiree benefits. In fact, most Medicare beneficiaries who do not otherwise have employer-sponsored supplemental coverage, Medicaid, or Medicare+Choice plans purchase Medigap policies, demonstrating the value of this coverage to the Medicare population.

Medigap Policies Can Have High Premiums

Medigap policies can be expensive. In 1999, the average annual Medigap premium was more than $1,300. Premiums varied based on the level of coverage purchased. Plan A, which provides the fewest benefits, was the least expensive, with average premiums of nearly $900 per year. (See table 3.) The most popular plans—C and F—had average premiums of about $1,200. The most comprehensive plans that pro-

[11] The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2000 Annual Survey (Menlo Park, Calif. and Chicago: 2000).

[12] Stephanie Maxwell, Marilyn Moon, and Mesha Segal, Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries (Washington, D.C.: Urban Institute, 2000).

[13] Maxwell, Moon, and Segal.

vide some drug coverage—I and J—were the most expensive, with average annual premiums around $1,700.

TABLE 3: DISTRIBUTION OF MEDIGAP PLANS AND ANNUAL PREMIUMS PER COVERED LIFE, 1999

Medigap plan	Covered lives (percentage)	Average annual premium
A	2.7	$877
B	7.8	1,093
C	15.7	1,158
D	3.7	1,032
E	1.5	1,067
F	22.9	1,217
G	1.5	981
H	1.4	1,379
I	1.5	1,698
J	2.6	1,672
Prestandard (policies sold before July 1992)	34.9	1,525
Plans in states in which insurers are exempt from offering standardized plan [a]	4.0	1,368
Total [b]	100.0 [c]	1,311

[a] Massachusetts, Minnesota, and Wisconsin have alternative plans in effect and waivers that exempt them from selling the national standard Medigap plans.

[b] Data reported by insurers to the National Association of Insurance Commissioners (NAIC) do not include plan type for policies representing less than 8 percent of Medigap policy covered lives, with an average paid premium of $1,275. These plans are not included in the table.

[c] Percentages do not add to 100 due to rounding.

Source: GAO analysis of data collected by the NAIC from the 1999 Medicare Supplement Insurance Experience Exhibit.

Medigap premiums also varied across geographic areas and insurers. For example, in 1999, average annual premiums in California were 35 percent higher than the national average for policies conforming to the standard plans. While premiums may reflect geographic differences in use of Medicare and supplemental services and costs, beneficiaries in the same state may face widely varying premiums for a given plan type offered by different insurers.[14] For example, in Illinois, plan A premiums for a 65-year-old ranged from $467 to $1,202, depending on the insurer. Similarly, in New York, plan F premiums for a 65-year-old ranged from $1,617 to $2,800, and in Texas, plan J premiums ranged from $2,059 to $5,658.

Medigap policies are becoming more expensive. One recent study reported that, from 1999 to 2000, premiums for the three Medigap plan types offering prescription drug coverage (H, I, and J) increased the most rapidly—by 17 to 34 percent. Medigap plans without prescription drug coverage rose by 4 to 10 percent.[15]

A major reason premiums are high is that a significant share of premium dollars is used for administrative costs rather than benefits. On average, more than 20 cents from each Medigap premium dollar is spent for costs other than medical expenses, including administration. Administrative costs are high, in part, because

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[14] Premium quotes are from 2000 and 2001 state consumers guides on Medigap policies.

[15] Weiss Ratings Inc, "Prescription Drug Costs Boost Medigap Premiums Dramatically," (Palm Beach Gardens, Fla.: Mar. 26, 2001). http://www.weissratings.com/NewsReleases/Ins—Medigap/20010326Medigap.htm (downloaded May 3, 2001).

nearly three-quarters of policies are sold to individuals rather than groups.[16] The share of premiums spent on benefits varies significantly among carriers. The 15 largest sellers of Medigap policies spent from 64 to 88 percent of premiums on benefits in 1999. The share of premiums spent on benefits is lower for Medigap plans than either typical Medicare+Choice plans or health benefits for employees of large employers. In comparison, 98 percent of Medicare fee-for-service funds are used for benefits.

Medigap Provides Limited Coverage for Prescription Drugs

Medigap policies can leave beneficiaries exposed to significant out-of-pocket costs for prescription drugs. Medigap policies with a drug benefit are expensive, yet the drug benefit offered can be of limited value to many beneficiaries. The Medigap annual prescription drug benefit has a $250 deductible, requires 50 percent coinsurance, and limits coverage to $1,250 or $3,000, depending on the plan purchased. These dollar amounts have not been increased since they were established in 1992. As a result of the deductible and coinsurance provisions, a beneficiary with Medigap plan type J would have to incur $6,250 in prescription drug costs to get the full $3,000 benefit. Moreover, Medigap policies offering drug coverage typically cost much more than policies without drug coverage. For example, plan type J—the most popular plan with prescription drug coverage—costs, on average, $450 a year more than the most popular plan without drug coverage (plan F).

Having a Medigap policy with drug coverage versus one without has little effect on beneficiaries' out-of-pocket spending on drugs. In 1998, Medigap policyholders with prescription coverage spent, on average, $548 out of pocket on prescription drugs. Medigap paid only 27 percent of policy holders drug costs. Medigap policyholders without prescription drug coverage spent, on average, $618 out of pocket on drugs—about 13 percent more than beneficiaries with drug coverage.

The high cost and limited benefit of existing Medigap plans may explain why more than 90 percent of beneficiaries with Medigap coverage purchased standard plans that do not include drug benefits.[17] Another reason is that, in most states, Medicare beneficiaries who do not purchase Medigap policies when they initially enroll in part B at age 65 or older are not guaranteed access to the Medigap policies with prescription drug coverage. For those beneficiaries, insurers may either deny coverage or charge higher premiums.

First-Dollar Coverage Increases Medigap Premiums and Weakens Medicare's Cost Control Features

The most popular Medigap plans are fundamentally different from other health insurance policies, which typically include cost-sharing provisions in the form of deductibles, coinsurance, and copayments. Cost-sharing requirements are intended to make beneficiaries aware of the costs associated with the use of services and encourage them to use these services prudently. In contrast, Medigap's first-dollar coverage—the elimination of any deductibles or coinsurance associated with the use of covered services—undermines this objective. All standard Medigap plans cover hospital and physician coinsurance, with some of them also covering the full hospital deductible, skilled nursing facility coinsurance, or the part B deductible. Nearly all beneficiaries purchasing a standard Medigap plan choose one that covers the full hospital deductible, and most select plans that cover the full skilled nursing home coinsurance and part B deductible. The president's proposed plan types would be different from the existing popular Medigap plans in that they would not include first-dollar coverage.

Medigap's first-dollar coverage reduces financial barriers to health care, but it also diminishes beneficiaries' sensitivity to costs and likely increases beneficiaries' use of services, adding to total Medicare spending. Having first-dollar coverage may also add to Medigap premiums. The extra spending induced by first-dollar coverage causes insurers' outlays to rise and likely increases Medigap premiums. The premiums may increase not only to cover the additional expected health care expenses but also insurers' administrative costs.

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[16] Federal law requires Medigap plans to spend at least 65 percent of premiums over time on benefits for policies sold to individuals and 75 percent for policies sold to groups. See 42 USC § 1395ss(r)(1)(A).

[17] While less is known about the benefits offered by prestandardized plans that were sold prior to 1992—representing about one-third of Medigap enrollment in 1999—one expert estimated that most are likely to have some coverage for prescription drugs but that this coverage is even more limited than that offered by the standardized plans. See Deborah J. Chollet, Mathematica Policy Research Inc., "Medigap Coverage for Prescription Drugs," testimony before the U.S. Senate Committee on Finance, April 24, 2001.

Our analysis and other research indicate that Medicare spends more on beneficiaries with supplemental insurance than on beneficiaries who have Medicare coverage only. For example, our analysis of the 1998 Medicare Current Beneficiary Survey data found that annual Medicare expenditures for beneficiaries with Medigap insurance were about $2,000 higher than for beneficiaries with Medicare only.[18] Medicare annual spending for beneficiaries with employer-sponsored plans was about $1,700 higher than for beneficiaries with Medicare only.

Some evidence suggests that first-dollar, or near first-dollar, coverage may partially be responsible for the higher spending. For example, one study found that beneficiaries with Medigap insurance use 28 percent more medical services (outpatient visits and inpatient hospital days) compared to beneficiaries who did not have supplemental insurance but were otherwise similar in terms of age, sex, income, education, and health status.[19] Service use among beneficiaries with employer-sponsored supplemental insurance was approximately 17 percent higher than the service use of beneficiaries with Medicare coverage only.

Unlike Medigap policies, employer-sponsored supplemental insurance policies and Medicare+Choice plans typically reduce beneficiaries' financial liabilities but do not offer first-dollar coverage. Although there is a wide variety in design of employer-sponsored insurance plans, many retain cost-sharing provisions. Medicare+Choice plans also typically require copayments for most services. Moreover, unlike the traditional fee-for—service program, Medicare+Choice plans require referrals or prior authorization for certain services to minimize unnecessary utilization.

Under the president's Medigap proposal, the two new plan types would require beneficiary cost-sharing and, in this way, would be similar to the features of employer-sponsored insurance plans. In eliminating first-dollar coverage, the proposal seeks to keep the new policies more affordable for beneficiaries and create incentives to restrain overall program spending.

Concluding Observations

Interest remains high in improving supplemental coverage available to Medicare beneficiaries while fostering the prudent use of health care services. The president's proposal to create two new plan types that require cost-sharing and provide coverage for prescription drugs seeks to balance access and affordability with incentives for beneficiaries to be cost-conscious. The exclusion of first-dollar coverage from the new Medigap policies would make them more like employer-sponsored supplemental insurance policies that include incentives to minimize unnecessary use. These reforms could serve the interests both of beneficiaries and the program, making drug coverage more affordable while helping to moderate program expenditures. Details of the president's proposal will reveal the extent to which the new plan types offer better value for beneficiaries' premium dollars than the existing Medigap plan types. In our view, an effective health insurance plan would discourage the inappropriate use of services and protect beneficiaries from catastrophic health expenses, including prescription drug costs. We look forward to working with this subcommittee as it considers various options to reform Medigap and improve health care coverage for individuals.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions that you or members of the subcommittee may have.

Contacts and Acknowledgments

For more information regarding this testimony, please contact me or James Cosgrove at (202) 512–7118. Other contributors to this product were Rashmi Agarwal, John Dicken, Hannah Fein, Jennifer Podulka, and Lisa Rogers.

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Chairman JOHNSON. Thank you very much. Dr. Young, a pleasure to have you with us today, as well.

[18] GAO–01–941.

[19] Sandra Christensen, Ph.D. and Judy Shinogle, M.S., "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," Health Care Financing Review 19 (1997).

STATEMENT OF DONALD A. YOUNG, M.D., PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Dr. YOUNG. Thank you, Mrs. Johnson, distinguished Members of the Subcommittee. I am Donald Young, M.D., President of the Health Insurance Association of America (HIAA). The HIAA's nearly 300 members provide health, long-term care, dental, disability——

Chairman JOHNSON. Don, could you get a little closer to the microphone, please?

Dr. YOUNG. Dental, disability, and Medicare supplemental coverage to more than 100 million Americans. We commend the President for his leadership, and this Committee for the efforts you are making to develop Medicare and Medigap policies that will better meet the needs and expectations of Medicare beneficiaries. And we greatly appreciate the opportunity to join in today's discussion.

Plans to supplement Medicare fill important gaps in Medicare coverage. About 20 million seniors have such supplemental coverage, either through an employer-sponsored retiree health plan, or through an individually purchased Medigap plan. Many other seniors have supplemental coverage through Medicare+Choice or Medicaid.

Surveys done by government agencies and by private pollsters regularly confirm that Medigap policy holders are satisfied or very satisfied with their coverage, and consider the policies a good or excellent value.

However, making improvements to Medicare benefits, especially with respect to prescription drug coverage, also means that the design of Medicare supplemental products would need to be reexamined. The President has devoted considerable attention to Medicare coverage gaps relating to prescription drugs, and recently proposed several mechanisms to help Medicare beneficiaries with these costs.

One of these mechanisms would involve the creation of two new Medigap plans. These plans are intended to offer enhanced coverage for prescription drugs, protect beneficiaries against catastrophic illness, and provide for nominal beneficiary cost sharing. And we heard more details about them just recently.

During 2000 and 2001, the National Association of Insurance Commissioners (NAIC) undertook a reexamination of the 10 standardized Medigap policies. The NAIC working group conferred with consumer representatives, State and Federal regulators, Medicare supplement insurance carriers, and their trade associations, including HIAA. Their final report contains a list of possible revisions for further consideration.

However, the report emphasizes that in the absence of overall Medicare reform, the implementation of incremental changes to Medigap may be ill advised, given the need for regulatory changes at the State level, the need for beneficiary education, and the potential for adverse selection.

I would like to offer a few recommendations about Medigap reform. First, since the design of any new or revised Medigap plans would be heavily dependent upon the features of a modernized Medicare program, we believe that Congress should make final decisions about the Medicare program itself, and then proceed to address corresponding Medigap issues.

Second, changes affecting Medigap should be made at one time, and not in an incremental or piecemeal fashion. Making Medigap changes in two or more rounds of reform would increase administrative costs and increase beneficiary confusion.

Third, we suggest that Congress allow a process similar to that used under the Omnibus Reconciliation Act 1990 for any mandated redesign of Medigap benefits. In 1990, the Congress did not specify in statute the contents of the 10 standardized Medigap plans we have today; but instead, called for the NAIC to bring together consumer representatives, State regulators, and insurers, to design Medigap benefit options. We believe it would be in the best interests of consumers to follow the same approach at the proper time.

Finally, it is important to remember that when it comes to Medigap, Medicare beneficiaries are the customers. They are free to buy, or to not buy, available products. Whatever we do must be viewed as beneficial, not harmful, to the interests of the typical Medicare beneficiary, and result in Medigap products that provide value and are affordable.

I will end by emphasizing that in the context of broader Medicare benefit modernization, HIAA certainly understands the need to take a fresh look at Medigap. We wish to bring the experience and views of our Member companies to this Committee's efforts to reexamine the structure of Medigap benefits and related matters.

Thank you again for giving me this opportunity to appear before you today, and I would be happy to take any questions you may have.

[The prepared statement of Dr. Young follows:]

Statement of Donald A. Young, M.D., President, Health Insurance Association of America

Introduction

Mr. Chairman, distinguished members of the Subcommittee, I am Donald A. Young, MD, President of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. Many of HIAA's members provide Medicare supplemental insurance products, including individual Medigap policies, and we, therefore, greatly appreciate the opportunity to join in today's discussion.

Current Medigap Market

Because Medicare was designed with deductibles and coinsurance, with limits on covered services, and with certain services not covered at all, there have been gaps in coverage from the very beginning. In fact, it's been estimated that Medicare covers only about half of the health care costs incurred by seniors and other beneficiaries, leaving many at significant financial risk for illness. Medicare supplemental insurance was designed to address this financial risk. Approximately 20 million seniors have Medicare supplemental coverage, either through an employer-sponsored plan for retirees (11.5 million beneficiaries) or through an individually purchased Medigap plan (8.4 million beneficiaries). Many other seniors have supplemental coverage through Medicare+Choice (5.5 million) or Medicaid (3.8 million). About 4.3 million beneficiaries have no supplemental coverage.[1]

In 1990 Congress mandated the creation of 10 standardized Medigap plans, Plans A through J. In addition, two high deductible policies were authorized by the Bal-

[1] Laschober, Mary A., Michelle Kitchman, Patricia Newman, and Allison A. Strabic, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996–1999," Health Affairs, February 27, 2002. Figures are for fall 1999, except for Medicare+Choice (6.0 million in fall 1999), which has been updated by CMS data to February 2002.

anced Budget Act of 1997. Three of the 10 standardized plans, H, I and J, and the J high deductible plan, provide limited coverage for prescription drugs.

Popularity of Medigap Among Seniors

Surveys conducted bi-annually by the Inspector General of the Department of Health and Human Services continue to show a high level of satisfaction among seniors with their Medigap coverage. A survey conducted last summer by a private company, American Viewpoint, found that 89 percent of respondents were satisfied or very satisfied with their Medigap coverage, while 76 percent of respondents said that, considering the premiums they pay, the policies are a good or excellent value. What they value most is peace of mind from knowing what their medical costs will be and the lack of paperwork—they don't have to hassle with medical bills. The vast majority (81%) would recommend Medigap coverage to a friend or relative when they turn 65 and enroll in Medicare.[2]

Transition Issues

In considering potential changes to Medigap, it is important to understand that essentially any change would raise a variety of transition issues that would need to be very carefully addressed. I'd like to take a few minutes to discuss the most important of these.

Treatment of old policies. One very important element of any Medicare and Medigap reform is the treatment of current Medigap policyholders. Public policy must be carefully crafted to support a stable supplemental insurance market and avoid adverse selection. When the 10 standardized plans were implemented in the early '90s, beneficiaries were granted a 6-month open enrollment period, during which they could purchase any of the new policies available in their state. They also were allowed to keep their pre-standardized policy instead of buying one of the new policies, if they preferred. The one-time opportunity to choose the desired level of supplemental coverage protects the market and the plans with richer benefits from rate spirals that result from adverse selection.

We envision a very different transition in the context of comprehensive Medicare and Medigap reform. Standardized policies A–J were designed to mesh with the current Medicare benefit structure. Comprehensive reform, which may entail eliminating the Part A and Part B distinction or otherwise changing the structure of beneficiary cost-sharing, will require that new standardized supplemental policies be defined which mesh with the new Medicare covered benefits. In that case, policyholders with plans A–J would most likely need to transition to new supplemental policies, and policies A–J would be retired. Having a one-time, limited open enrollment opportunity for the new supplemental policies, in the context of comprehensive reform, should be workable (in terms of the hazards of adverse selection) because all beneficiaries (the more healthy and less healthy) will be moving into the new policies.

Regulatory implementation. Another important element of transition from current Medigap offerings to new supplemental policies is regulatory implementation. In a process created by OBRA 1990, Congress preserved for the States (and the National Association of Insurance Commissioners (NAIC)) the role of defining detailed standards and regulating Medigap carriers. Thus, after Congress enacts guidelines for reformed supplemental benefits, the NAIC must design new standardized policies and develop model regulations, and the Department of Health and Human Services must adopt the NAIC model as part of the federal requirements. Subsequently, each state must change its laws and regulations to implement the new requirements, to ensure that state requirements are at least as stringent as federal requirements.

Since states play a central role in regulating Medigap insurance, Congress must recognize that this process takes time, and the implementation period must be sufficiently long to allow for this. The timeline set under the BBA for implementing the new standardized high deductible policies was too short, and much confusion resulted. On the other hand, we also believe that the NAIC would need to consider some form of "speed to market" arrangement for any reformed Medigap plan offerings so that the opportunity for beneficiaries to purchase better coverage is not unduly delayed.

Education. Yet another very important element of transition is education. Clearly provisions for adequate regulator, insurer, agent, and beneficiary education are essential in order for beneficiaries to receive the supplemental insurance options in-

[2] AmericanViewpoint, National Medigap Enrollees Survey, Conducted for the Coalition to Preserve Choice for Seniors, June 22–July 1, 2001.

tended by Congress. Because reeducation in the Medigap market is such a massive undertaking, and because the market has experienced much stress in recent years, the frequency with which Congress changes Medigap standards should be kept to a minimum.

NAIC Consideration of Medigap Reform

In considering Medigap reform, we believe it is useful to review recent efforts by the NAIC. In 2000 and 2001, the NAIC undertook a reexamination of the 10 standardized Medigap policies, assigning the task to the Medicare Supplement Working Group. In conducting its examination, the Working Group conferred with consumer representatives, state and federal regulators, Medicare supplement insurance carriers and their trade associations, including HIAA. Through a seven-month structured fact-finding process, the Working Group elicited statistical data, information and opinions from the various interested parties. And, at the 2000 NAIC Winter National Meeting, the working group held a public hearing.

The final report of the Working Group,[3] adopted by the NAIC Health Insurance & Managed Care (B) Committee on December 10, 2001, contains a list of possible revisions for further consideration—but only in the context of comprehensive Medicare reform. Importantly, the report highlights a number of concerns about the prospect of numerous, incremental changes to Medigap. In this regard, relevant excerpts from the report include the following:

- "In the absence of comprehensive Medicare and Medigap reform, which would need to contain appropriate transitional periods for relevant Medigap blocks of business and implementation of amended state regulations, most interested parties cautioned against incremental changes to the Medigap benefit design."
- "It is important to note [that] frequent changes in Medigap benefits are costly and confusing to beneficiaries."
- "Any revision to the [Medigap] standardized plans must consider the transition issues that involve regulatory changes, beneficiary education, and adverse selection where existing plans are grandfathered."

The Working Group's report does present a number of suggested modifications to Medigap benefits "if larger Medicare reform is adopted, thus necessitating changes to Medigap." Examples include the following:

- Delete coverage for services that are now Medicare covered services (e.g. certain preventive benefits), or that are no longer needed due to Medicare program changes (e.g. coverage for excess charges, coverage for at home recovery).
- Consider including new benefits (e.g. cost-sharing for Medicare hospice benefit).
- Include deductibles and copayments/coinsurance to create incentives for appropriate service utilization.
- Have fewer standardized plans.
- Allow use of benefit utilization controls such as tiered drug formularies in those Medigap plans that include prescription drug coverage.

The Issue of First-Dollar Coverage

The announcement for this hearing expressed concern about the fact that many of the Medigap plans purchased by seniors cover Medicare Part A and Part B deductibles as well as Part A copayment and Part B coinsurance amounts. This is typically referred to as first-dollar coverage. The concern is that first-dollar coverage, by lessening beneficiary price sensitivity, may increase Medicare spending, perhaps inappropriately.

This is not a new issue, and things are not as simple as they might first appear. To begin with, not all Medigap plans provide full first-dollar coverage. However, it is certainly true that those that do are the most popular plans among the nation's seniors. Medigap plans C, F and J are the three that cover both the Part A and Part B deductibles. These three plans are twice as popular as the other seven plans combined. This popularity is likely due to the fact that Medicare beneficiaries are risk averse and derive a great deal of financial and personal security from their supplemental insurance policies.

Moreover, under the Balanced Budget Act of 1997, Congress provided for two, new high-deductible Medigap products. However, few such plans have actually been sold, and there are reports that the biggest hurdle to the sale of these products is over-

[3] "Report on Revisiting Medicare Supplement Insurance Standardized Plans," Final Report of the Medicare Supplement Working Group of the NAIC Senior Issues Task Force. December 10, 2001

coming beneficiary expectations that a Medigap plan will provide first-dollar coverage. Thus, any Congressional plan to restrict Medigap first-dollar coverage of deductibles and other cost-sharing obligations is likely to require considerable Medicare beneficiary education and involvement in order to overcome expected beneficiary resistance to this idea.

Second, if Medicare spending is higher for beneficiaries who purchase a Medigap plan with first-dollar coverage, it cannot automatically be assumed that such spending is for medically inappropriate or unnecessary services. Medicare's existing coverage and utilization review mechanisms are specifically designed to assure that Medicare pays only for items and services that are reasonable and necessary. Medicare supplemental insurers do not make independent coverage decisions. Thus, attempts to move away from first-dollar coverage might in fact impose barriers to the receipt of necessary care. A special study performed a few years ago for HIAA by Gerard Anderson and his colleagues at Johns Hopkins noted that the burden of Medicare cost-sharing is distributed unequally across beneficiaries, increasing as they become older, develop chronic illnesses, or have catastrophic illnesses.[4] Supplemental insurance spreads this risk, thereby reducing the financial burden on older beneficiaries and those with chronic or catastrophic illnesses.

Dr. Anderson's study also noted that the available literature suggested that Medicare beneficiaries' price sensitivity is greatest for preventive and physician services. According to Dr. Anderson's study, Medicare beneficiaries without supplemental insurance were much less likely to have flu shots, mammograms, and pap smears. For this and other reasons, Dr. Anderson cautioned that comparisons of the Medicare expenditures incurred by beneficiaries with supplemental coverage and those who do not overestimate the effect of supplemental insurance on Medicare spending.

Even the celebrated RAND Health Insurance Experiment, which investigated the impact of cost-sharing on health care utilization by a non-elderly population, found that when faced with cost-sharing, individuals were just as likely to limit the use of "highly effective" care as "less effective" care. Thus, as far as we can determine, the Medicare savings predicted from restrictions on first-dollar coverage of Medicare deductible and coinsurance amounts would, at least to some extent, be due to the fact that beneficiaries would be discouraged from seeking medically appropriate care. In a report last year, the Congressional Budget Office acknowledged that "the decrease in use of services by Medigap policyholders" produced by restrictions on first-dollar coverage "might not be limited to unnecessary care, so the health of some policyholders might be adversely affected."[5]

Medigap Benefit Design

The committee's announcement for this hearing also questioned the value of one of the prescribed benefits for most Medigap policies, foreign travel insurance, asserting that most beneficiaries never leave their home country. This benefit covers 80 percent of the medically necessary emergency care received in a foreign country, after a $250 deductible, up to a lifetime maximum of $50,000.

Ideally, any redesign of Medigap benefits would take account of the needs and preferences of today's seniors. Many seniors do travel outside the United States, and may well value the peace of mind associated with Medigap coverage when they do so. On the other hand, if a benefit is infrequently used, it does not contribute very much to product pricing, and so dropping the benefit would not, by itself, produce much benefit.

In this regard, it also needs to be remembered that current law requires that Medigap products be guaranteed renewable. This means that a Medigap policy may not be cancelled or have its benefits changed. Thus, any revisions to current Medigap benefits would raise very important transition issues, which are likely to be complex and difficult to resolve.

In the case of the elderly, many of whom suffer from chronic illnesses, treatment costs for such things as prescription drugs and regular physician office visits can be more or less predictable. This relative predictability certainly permits each beneficiary to make a reasoned economic judgment about the expected near-term value of an insurance product. In other words, beneficiaries can be expected to do the math, comparing anticipated benefits with known premium costs. This raises the potential that healthier Medicare beneficiaries will seek out lower cost Medigap products or even decide to self-insure, thereby further driving up the average costs of

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[4] Anderson, GF; Wiest, A; Shaffer, T; Hussey, P; and Bilenker, J. *Concerns About the Theory of Increased Cost-Sharing for Medicare Beneficiaries and Its Policy Implications for the Medicare Program.* Washington, DC: Health Insurance Association of America. 1999.

[5] Congressional Budget Office, *Budget Options*, February 2001.

coverage for those remaining behind. As insurers know only too well, benefit redesign, if not very carefully done, can lead to adverse selection and ultimately make the re-designed insurance product simply unaffordable for the average citizen.

Bush Administration Proposals

As part of his fiscal year 2003 budget plan, President George W. Bush has proposed several mechanisms for providing prescription drug benefits for Medicare beneficiaries. One of these would involve the creation of two new Medigap plans. These plans would offer prescription drug coverage, protect beneficiaries against catastrophic illness, and include nominal beneficiary cost-sharing, all presumably for a lower premium cost than the most popular Medigap plans today.

To date, few details have been released about the exact nature of the benefits for the two new Medigap plans or how they would be implemented. For example, the degree to which the new products would or would not provide coverage for Medicare deductibles and other beneficiary cost-sharing obligations has not been spelled out. The Administration maintains that the new plans will offer better benefits at a lower premium than the most popular Medigap plans today. However, it seems more likely that these new policies would require premiums comparable to, or even higher than, the premiums for today's most popular policies, especially since they promise more generous prescription drug benefits than current Medigap policies, catastrophic expense protection, and only "nominal" beneficiary cost sharing obligations.

Furthermore, there appears to be considerable risk that the new Medigap products would be subject to adverse selection, since they would be more likely to appeal to beneficiaries expecting high health care utilization (e.g., high prescription drug costs). This risk, would likely discourage Medigap carriers from offering the new products, especially since they would expect to find it difficult to secure from state regulators future rate adjustments needed to cover the level of cost increases induced by adverse selection and rising prescription drug costs. In this context, it goes without saying that Medigap carriers would strongly oppose any attempt to require them to offer the new Medigap options. Such a mandate could prompt some carriers to exit the Medigap market entirely.

HIAA certainly looks forward to getting more information about the President's Medigap proposal and to helping the Congress assess its various components. We certainly share everyone's desire to find ways to better meet the needs of Medicare beneficiaries.

HIAA's Recommendations to the Congress

What I have tried to do today is to provide a context for the understandable desire to reform not only the basic Medicare program, but Medigap coverage options as well. I hope it is apparent that even the most tempting Medigap reforms would need to navigate some difficult ground. The design of any new or revised Medigap plans would, of course, be heavily dependent upon the features of a modernized Medicare program. Thus, it seems to us that the Congress should first make decisions about the Medicare program itself, and then proceed to address corresponding Medigap issues.

HIAA also believes that changes to Medigap policies should be done in conjunction with comprehensive changes in Medicare benefits, and not before that time. Further, changes affecting Medigap should be made at one time and not in an incremental or piecemeal fashion. Making Medigap changes in two or more "rounds of reform" would add significantly more administrative costs to the system than making such changes at one time, and would likely increase beneficiary confusion.

We would also suggest that Congress provide as much flexibility as possible for any mandated redesign of Medigap benefits. As you know, under the Omnibus Budget Reconciliation Act of 1990, the Congress did not specify the contents of the 10 standardized Medigap plans we have today, but instead allowed for a process where consumer representatives, state regulators, and insurers worked together to design Medigap benefit options. Similarly, we believe that it would be extremely risky for Congress to mandate by statute the contents of insurance products intended for voluntary sale and purchase in the private marketplace.

Finally, to state the obvious, when it comes to Medigap, Medicare beneficiaries are the customers, and they are free to buy—or not buy—available products. In the end, whatever we do must be viewed as beneficial, not harmful, to the interests of the typical Medicare beneficiary, and result in Medigap products that are affordable.

Conclusion

I hope that my testimony today helps elucidate the many issues that arise in any consideration of changes to Medigap. HIAA is open to considering Medigap reforms, such as those catalogued in the NAIC Medicare Supplement Working Group report, in the context of broader reform of Medicare covered benefits. However, without knowing how the core Medicare benefit package is structured, it is difficult, if not impossible to properly evaluate the merit of individual Medigap reform suggestions. In addition, some suggestions may not be well received by Medicare beneficiaries, could risk subjecting Medigap plans to adverse selection, or might otherwise endanger the important goal of maintaining affordable Medigap products. In any case, HIAA and its member companies look forward to working with this committee to craft feasible Medicare and Medigap policies that will meet the needs and expectations of Medicare beneficiaries.

HIAA Traditional Members

Academy Life Insurance Company—Frazer, PA

AEGON USA, Inc.—Baltimore, MD

AF&L Insurance Company—Warrington, PA

Affiliated Health Plans, Inc.—Thousand Oaks, CA

AFLAC—Columbus, GA

American Casualty Company—Chicago, IL

American Casualty Company of Reading, Pennsylvania—Reading, PA

American Family Mutual Insurance Company—Madison, WI

American Fidelity Assurance Company—Oklahoma City, OK

American Heritage Life Insurance Company—Jacksonville, FL

American Medical Security Life Insurance Co of GA—Green Bay, WI

American Medical Security, Inc.—Green Bay, WI

American Republic Insurance Company—Des Moines, IA

American Specialty Health Incorporated—San Diego, CA

American Specialty Health Plans of California, Inc.—San Diego, CA

American Specialty Health Networks—San Diego, CA

American Specialty Health Care, Inc.—San Diego, CA

American Specialty Health IPA of New York, Inc.—San Diego, CA

AON Corporation Group—Chicago, IL

AUL Long Term Care Solutions, Inc.—Avon, CT

AUL Reinsurance Management Solutions—Avon, CT

AultCare—Canton, OH

AUSA Life Insurance Company—Purchase, NY

Bankers Life and Casualty Company—Chicago, IL

Manhattan National Life Insurance Company—Carmel, IN

Mayflower Insurance Company, Ltd.—New York, NY

Mayflower National Life Insurance Company—Indianapolis, IN

McKinley Life Insurance Company—Canton, OH

MedAmerica Insurance Company—Pittsburgh, PA

MedAmerica Insurance Company of New York—Rochester, NY

Mennonite Mutual Aid Association—Goshen, IN

Metropolitan Life Insurance Company—New York, NY

Mid-South Insurance Company—Omaha, NE

MMA Insurance Company—Goshen, IN

Monitor Life Insurance Company of New York—Utica, NY

Montgomery Ward Insurance Company—Schaumburg, IL

Monumental General Insurance Company—Baltimore, MD

Monumental Life Insurance Company—Baltimore, MD

Munich American Reassurance Company—Atlanta, GA

Mutual of Omaha Health Plans, Inc.—Omaha, NE

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Blue Cross and Blue Shield of Georgia, Inc.—Atlanta, GA
Blue Cross Blue Shield Healthcare Plan of Georgia—Atlanta, GA
Blue Cross of California—New Bury Park, CA

Boston Old Colony Insurance Company—New York, NY
Buckeye Union Insurance Company—Columbus, OH
CaliforniaCare Health Plans—Thousand Oaks, CA
CHCS Services, Inc.—Weston, FL
Celtic Insurance Company—Chicago, IL

Central Reserve Life Insurance Company—Strongsville, OH
Central States Health & Life Company of Omaha—Omaha, NE
Ceres Group, Inc.—Strongsville, OH
CNA—Chicago, IL

CNA Casualty Company of California—Los Angeles, CA
CNA Lloyd's of Texas—Bellaire, TX

Columbia Casualty Company—Chicago, IL

Combined Insurance Company of America—Chicago, IL
Combined Life Insurance Company of New York—Latham, NY
Commercial Insurance Company of Newark, NJ—New York, NY
Commercial Travelers Mutual Insurance Company—Utica, NY
Companion Life Insurance Company—Rye, NY
Conseco Direct Life Insurance Company—Philadelphia, PA
Conseco Health Insurance Company—Carmel, IN
Conseco Life Insurance Company—Carmel, IN
Conseco Medical Insurance Company—Carmel, IN
Conseco Senior Health Ins. Co.—Carmel, IN

Conseco Services, LLC—Rockford, IL
Conseco Variable Insurance Company—Carmel, IN
Conseco, Inc.—Carmel, IN

Continental Assurance Company—Chicago, IL

Continental Casualty Company—Chicago, IL

Continental General Insurance Company—Omaha, NE
Continental Insurance Company—New York, NY
Pacific Insurance Company—New York, NY

Pacific Life & Annuity Company—Newport Beach, CA
Pacific Life Insurance Company—Newport Beach, CA
Pan American Insurance Company—San Juan, PR
Pension Life Insurance Company of America—Frazer, PA
Peoples Benefit Life Insurance Company—Cedar Rapids, IA
Physicians Mutual Insurance Company—Omaha, NE
Pioneer Life Insurance Company—Carmel, IN
Principal Financial Group—Des Moines, IA
Principal Life Insurance Company—Des Moines, IA
Providian Life and Health Insurance Company—Frazer, PA
Pyramid Life Insurance Company—Mission, KS
Pyramid Services, Inc.—Danbury, CT
QualChoice Health Plan, Inc.—Cleveland, OH
Security General Life Insurance Company—Oklahoma City, OK
Senior American Life Insurance Company—Warrington, PA
Sentry Insurance A Mutual Company—Stevens Point, WI
Sentry Insurance Group—Stevens Point, WI

Sentry Life Insurance Company—Stevens Point, WI
Sentry Life Insurance Company of New York—Syracuse, NY
Sentry Select Insurance Company—Stevens Point, WI
Starmark—Lake Forest, IL
State Farm Fire and Casualty Company—Bloomington, IL
State Farm General Insurance Company—Bloomington, IL
State Farm Insurance—Bloomington, IL
State Farm Mutual Automobile Insurance Company—Washington, DC
Sterling Life Insurance Company—Phoenix, AZ
Stonebridge Insurance Company—Plano, TX
Teachers Insurance and Annuity Association—New York, NY
Teachers Protective Mutual Life Insurance Company—Lancaster, PA
Transamerica Life Insurance & Annuity Company—Charlotte, NC
Transamerica Life Insurance Company of New York—Purchase, NY
Transamerica Occidental Life Insurance Company—Los Angeles, CA
Transcontinental Insurance Company—New York, NY

HIAA Traditional Members—Continued

Continental Insurance Company of New Jersey—New York, NY
Continental Insurance Company of Puerto Rico—Chicago, IL
Continental Lloyd's Company—Chicago, IL
Continental Reinsurance Corporation—New York, NY
CoreSource—Anderson, IN
CoreStar—Lake Forest, IL
Cost Care, Inc.—Huntington Beach, CA
Country Life Insurance Company—Bloomington, IL
Destiny Health, Inc.—Bethesda, MD
Employers Dental Services, Inc.—Des Moines, IA
Exclusive Healthcare, Inc.—Omaha, NE
Federated Insurance Companies—Owatonna, MN
Fidelity and Casualty Company of New York—New York, NY
Firemen's Insurance Company of Newark, New Jersey—New York, NY
First Fortis Life Insurance Company—Syracuse, NY
Fortis Benefits Insurance Company—Kansas City, MO
Fortis Health—Milwaukee, WI
Fortis, Inc.—New York, NY
Frontier National Life Insurance Company—Carmel, IN
GE Financial Assurance—Richmond, VA
GE Group Life Assurance Company—Enfield, CT
General & Cologne Life Re of America—Stamford, CT
General Electric Capital Assurance—San Rafael, CA
Glen Falls Insurance Company—New York, NY
Greater Georgia Life Insurance Company, Inc.—Atlanta, GA
Guarantee Trust Life Insurance Company—Glenview, IL
Guardian Insurance & Annuity Company, Inc.—New York, NY
Guardian Life Insurance Company of America—New York, NY
Healthyroads, Inc.—San Diego, CA
Illinois Mutual Life Insurance Company—Peoria, IL
J.C. Penney Life Insurance Company—Plano, TX
John Alden Life Insurance Company—Miami, FL
Transportation Insurance Company—Chicago, IL
Trustmark Insurance Company—Lake Forest, IL
Trustmark Life Insurance Company—Lake Forest, IL
UNICARE—Huntington Beach, CA
UNICARE Health Insurance of the Midwest—Chicago, IL
UniCARE Insurance Company—Camarillo, CA
UNICare Life & Health Insurance Company—Springfield, MA
Union Fidelity Life Insurance Company—Fort Washington, PA
United Behavorial Health—San Francisco, CA
United HealthCare of Arizona, Inc.—Minnetonka, MN
United HealthCare of California, Inc.—Minnetonka, MN
United HealthCare of Colorado, Inc.—Minnetonka, MN
United HealthCare of New Jersey, Inc.—Minnetonka, MN
United HealthCare of New York, Inc.—Minnetonka, MN
United HealthCare of the Midlands Inc—Omaha, NE
United HealthCare of Upstate New York, Inc.—Minnetonka, MN
United HealthCare of Utah—Salt Lake City, UT
United of Omaha Life Insurance Company—Omaha, NE
United Resource Networks—Minneapolis, MN
United Wisconsin Life Insurance Company—Green Bay, WI
United World Life Insurance Company—Omaha, NE
UnitedHealth Group—Minnetonka, MN
UnitedHealthcare—Hartford, CT
USAA Life Insurance Company—San Antonio, TX
Valley Forge Insurance Company—Reading, PA
Valley Forge Life Insurance Company—Reading, PA
Veterans Life Insurance Company—Frazer, PA
Wabash Life Insurance Company—Carmel, IN
Wausau Benefits, Inc.—Wausau, WI
WellPoint Health Networks Inc.—Thousand Oaks, CA
WellPoint Pharmacy Plan—Thousand Oaks, CA
Western Diversified Life Insurance Company—San Diego, CA

HIAA Traditional Members—Continued

John Hewitt & Associates—Portland, ME
Kansas City Fire and Marine Insurance Company—New York, NY
Liberty Life Assurance Company of Boston—Boston, MA
Liberty Mutual Group—Boston, MA
Liberty Mutual Insurance Company—Dover, NH
Life Investors Insurance Company of America—Cedar Rapids, IA
LifeCare Assurance Company—Woodland Hills, CA
LifePlans, Inc.—Waltham, MA
Woodmen of the World Life Insurance Society—Omaha, NE
World Insurance Company—Omaha, NE
Zurich American Insurance Company of Illinois—Schaumburg, IL
Zurich American Insurance Group—New York, NY
Zurich American Life Insurance Company—Schaumburg, IL
Zurich Insurance Company—Schaumburg, IL
Zurich Life Insurance Company—Schaumburg, IL

Chairman JOHNSON. Thank you very much, Dr. Young. Jennifer Weiss, of the Medicare Rights Center in New York, nice to have you.

STATEMENT OF JENNIFER WEISS, DIRECTOR OF POLICY, MEDICARE RIGHTS CENTER, NEW YORK, NEW YORK

Ms. WEISS. Thank you. Good afternoon. As Chairwoman Johnson said, my name is Jennifer Weiss, and I am the Director of Policy at the Medicare Rights Center. The Medicare Rights Center is a national consumer services organization based in New York that is dedicated to ensuring that older and disabled Americans get good, affordable health care. Every year we hear from more than 60,000 people with Medicare who have questions about their Medicare rights, benefits, and options. I thank the Ways and Means Subcommittee on Health for giving me this opportunity to testify on Medicare supplemental insurance options.

For the older and disabled men and women we serve, there are three critical Medigap issues: They want meaningful and understandable Medigap policies, a good Medigap benefit package, and affordable Medigap coverage. To the extent Medigap reform proposals affect these key issues, on behalf of our clients, we ask that you tread carefully.

As you well know, changes often have unintended consequences. Adding new Medigap plans that are not affordable, or that discourage access to needed care, will jeopardize the health of older and disabled Americans. Changes designed to save money by dissuading people from seeking the care they need may end up costing Medicare more in the long run, through future hospitalizations and through providing other complex health services.

Any new Medigap option must be designed so that people can easily understand its risks and benefits. For example, there is incontrovertible evidence that Medigap standardization has been successful in allowing consumers a meaningful basis to comparison shop—a good thing for consumers and for the market.

In an ideal world, there would be a simple answer to the question of how to design cost sharing in Medigap that strikes the right

balance between ensuring that people who need care get care, and discouraging people from seeking unnecessary care. Finding that delicate balance requires a fair and objective review of our learning on health care usage.

Based on our experience, we have two serious concerns that we raise here: One, plans that do not provide first-dollar coverage might deter enrollees from getting needed care. Two, plans that do not provide first-dollar coverage might draw a healthier pool of policy holders, which could lead Medigap insurers to raise rates on the less-healthy pool of policy holders who elect first-dollar coverage plans.

Moreover, plans with high deductibles are not likely to attract customers. As you know, the two high-deductible plans currently available have few enrollees. Today, many more people sign up for plans that cover their high deductibles and high cost sharing than for less expensive plans that do not. In fact, most people even opt for plans that cost more but cover the modest part B deductible.

Regardless of ideology, none of us wants a health care system that deters people from getting the care they need. At the same time, limited public resources should not be diverted to pay for care that is unnecessary. We need to understand clearly where the dividing line is.

The tragedy that we hear at the Medicare Rights Center day after day is from our elderly clients who report that they go without needed care because they cannot afford it. As you well know, prescription drugs are the prime example of what we consider to be an inhumane and uncivilized deprivation in modern-day America. Remember, the Medicare population is a group of Americans who have a median income below $24,000 a year. Indeed, Members of the Committee, our neighbors are going without needed care as we meet here today.

Our client experiences also tell us that Medigap policies are the mechanism through which our clients budget for their health care each month, enabling them to predict many of the costs they will face. Human beings, of course, are not clairvoyant and are hard-pressed to self-insure for unexpected high-cost health care needs. While a high-deductible Medigap plan may mean a beneficial lower monthly Medigap premium, it may also mean a gamble about future health care needs and out-of-pocket health care costs.

As this Committee considers ways to offer people with Medicare meaningful health care choices, encourage access to needed care, and discourage unnecessary care, we would urge you to look at Medicare as a mechanism for offering supplemental options. Adding supplemental coverage options to Medicare would allow the millions of people with disabilities under 65 the right to purchase coverage. It could also spread risk more broadly, and help stabilize supplemental insurance premiums. We wonder whether the CBO has ever scored this proposal to expand Medicare, and strongly recommend that you request further study of this option.

To conclude, we strongly urge that before pushing forward with changes to Medigap, that you ask the GAO and the CBO to study these proposed changes and their potential consequences. Add to the current Administration proposals serious review of other options, such as a supplemental policy directly through Medicare.

No one expected that the Balanced Budget Act of 1997 would lead to 2.2 million Americans losing their health maintenance organization (HMO) coverage, and thousands struggling to secure a Medigap policy. No one would want to offer a change to Medigap that impeded access to needed care. That said, the greatest barrier to getting care right now is the lack of a Medicare prescription drug benefit. Prescription drug coverage through Medigap has proven to be unworkable. Now is the time for Congress to expand Medicare to include prescription drug coverage for everyone. Thank you very much.

[The prepared statement of Ms. Weiss follows:]

Statement of Jennifer Weiss, Director of Policy, Medical Rights Center, New York, New York

Introduction

My name is Jennifer Weiss and I am the director of policy at the Medicare Rights Center. The Medicare Rights Center is a national consumer service organization, based in New York, working to ensure that older and disabled Americans get good, affordable health care. Under a contract with the New York State Office for the Aging, with funding from the Centers for Medicare and Medicaid Services, we operate New York State's Health Insurance Assistance Program hotline. Every year we hear from more than 60,000 people with Medicare, who have questions about their Medicare benefits, rights and options. We also operate a National Medicare HMO Hotline that assists elderly and disabled Americans who are struggling to get needed care and coverage from their HMOs. I thank the Ways and Means Subcommittee on Health for this opportunity to testify on Medicare Supplemental Insurance policies.

For the older and disabled men and women we serve, there are three critical Medigap issues: they want meaningful and understandable Medigap choices, a good Medigap benefit package, and affordable Medigap coverage. To the extent Medigap reform proposals affect these key issues, on behalf of our clients, we ask that you tread carefully. As you well know, changes often have unintended consequences. Adding new Medigap plans that are not affordable, or that lead to increases in the premiums charged for other Medigap plans, or that discourage access to needed care, will jeopardize the health of older and disabled Americans. At the same time, changes designed to save money by discouraging access to needed care may end up costing Medicare more in future hospitalizations and other complex health services.

Any new Medigap option must be designed so that people can easily understand its risks and benefits. For example, there is incontrovertible evidence that Medigap standardization has been successful in allowing consumers a meaningful basis to comparison shop—a good thing for consumers and for the market.

Medigap first dollar coverage

In an ideal world there would be a simple answer to the question of how to design cost-sharing in Medigap that strikes the right balance between ensuring that people who need care get care and discouraging people from seeking unnecessary care. Finding that delicate balance requires a fair and objective review of our learning on health care usage. Based on our experience, we have two serious concerns that we raise here: One, plans that do not provide first dollar coverage might deter people who elect these plans from getting needed care. Two, plans that do not provide first dollar coverage might draw a healthier pool of policyholders, which could lead Medigap insurers to raise rates on the less healthy pool of policyholders who elected first dollar coverage plans. Moreover, plans that do not provide first dollar coverage are not likely to attract subscribers. As you know, the two high deductible plans currently available have few subscribers. Today, many more people sign up for plans that cover their high deductibles and high cost sharing than for less expensive plans that do not.

Regardless of ideology, none of us wants a health care system that deters people from getting needed care. At the same time, limited public resources should not be diverted to pay for unnecessary care. We need to understand clearly where the dividing line is. The tragedy we hear at the Medicare Rights Center, day after day, is from our elderly clients who report that they go without needed care because they cannot afford it. As you well know, prescription drugs are the prime example of what we consider to be an inhumane and uncivilized deprivation in modern day

America. Remember, the Medicare population is a group of Americans who have a median income below $24,000 a year. Indeed, members of the Committee, our neighbors are going without needed health care as we meet today.

Our client experiences also tell us that Medigap policies are the mechanism through which our clients budget for their health care each month, enabling them to predict many of the costs they will face. Human beings, of course, are not clairvoyant and are hard-pressed to self-insure for unexpected high cost health care needs. While a high-deductible Medigap plan may mean a beneficial lower monthly Medigap premium, it may also mean a gamble about future health care needs and out-of-pocket costs that keep people from getting necessary care.

Reducing first dollar costs

As this Committee considers ways to offer people with Medicare meaningful health care choices, encourage access to needed care and discourage unnecessary care, we would urge you to look at offering supplemental coverage options directly through Medicare with a co-pay and a premium. Adding supplemental coverage options to Medicare would allow the millions of people with disabilities under 65 the right to purchase coverage, promoting their access to needed care. It could also spread risk more broadly and help stabilize supplemental insurance premiums. We wonder whether the Congressional Budget Office has ever scored this proposal to expand Medicare and strongly recommend that you request further study of this option.

Access to Medigap and Prescription Drug Coverage

To conclude, we strongly urge that before pushing forward with changes to Medigap that you ask the GAO and the CBO to study these proposed changes and their potential consequences. Add to the current Administration proposals serious review of other options, such as a supplemental policy directly through Medicare. No one expected that the Balanced Budget Act of 1997 would lead to 2.2 million Americans losing their HMO coverage and thousands struggling to secure a Medigap policy. No one would want to offer a change to Medigap that impeded access to needed care. That said, the greatest barrier to needed care right now is the lack of a Medicare prescription drug benefit. Prescription drug coverage through Medigap has proven to be unworkable. Now is the time for Congress to expand Medicare to include prescription drug coverage for everyone.

Thank you.

Chairman JOHNSON. Thank you very much, Ms. Weiss. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

Ms. Weiss, your last statement was that, "Providing prescription drugs through Medigap policies has proven to be unworkable," I believe is what you said.

Ms. WEISS. Yes.

Mr. MCCRERY. Why do you think that is?

Ms. WEISS. I would say that I believe that is the case because only between 8 and 10 percent of people who have Medigap have chosen the Medigap plans that offer prescription drug coverage. The fact that they have only a 50-cents-on-the-dollar coverage and high deductibles means that people essentially have to spend over $6,000 to get $3,000 worth of coverage. So my sense is that the Medigap plans that do offer prescription drug coverage are not a good value. And we have seen that indicated by the few number of enrollees who have actually signed up for them.

Mr. MCCRERY. Dr. Young, do you agree with that analysis?

Dr. YOUNG. Yes. That is the same that we hear back. The Medicare beneficiaries look at that and say, "This is not a good deal for me, and I'll choose one of the other options."

Mr. MCCRERY. And why is the price so high in relation to the benefit for those policies?

Dr. YOUNG. That has to do with the problem of selection, of adverse selection. And Medicare's beneficiaries with drug costs have a very good idea of what their drug costs are going to be; if they are going to be $500 or less, or if they are going to be $1,000 or $2,000. So they can go through the arithmetic. And if they are going to have high drug costs, then they are likely to pick that option, and they will be in that 8 or 9 percent.

That results, though, in the premiums going up, because everybody there has drug costs that are much higher than average. You cannot spread the costs across a larger group and keep the premiums lower.

Mr. MCCRERY. So Mr. Jindal, how do we solve that problem? If we cannot provide prescription drugs effectively to the Medicare population, to the universe of Medicare beneficiaries, through Medigap policies, because of adverse selection, how do we solve that problem?

Mr. JINDAL. Well, I also want to add that one of the concerns we have with the Medigap policies, in addition to what the previous two speakers said and what the Chair has said, is the problem being that you have to buy all of these other benefits before you get to the prescription drug coverage. It is not possible to get the drug coverage unless you buy first-dollar coverage.

So I think a couple of principles the Administration is in support of is, first, no longer requiring beneficiaries to buy first-dollar coverage for other utilization before they get prescription drugs. Second, we do believe that, if offered through risk-bearing, integrated plans, if you buy drug coverage that includes not a capped drug coverage, but also includes catastrophic coverage, you will get a better sharing of that risk.

So two changes would be, first, divorcing it from having to buy first-dollar coverage and, second, not making it a capped benefit, but rather making it a catastrophic benefit in an integrated, privately offered, risk-bearing plan, would be a way to get more affordable drug coverage to Medicare seniors.

Mr. MCCRERY. Bottom line, though, if we are going to have effective and affordable prescription drug coverage, do we not have to pretty much spread that across the Medicare population?

Mr. JINDAL. Yes.

Mr. MCCRERY. Then that brings me to Mr. Stark's question, or his statement, that a Federal program would be 20 percent less expensive to provide than private programs. That does not seem to be the way the administration is going; and I doubt if that is the way Dr. Young would want to go. So maybe you would like to comment on Mr. Stark's proposal.

Mr. JINDAL. I would be happy to start. I would like to follow up that the Administration certainly, in addition to supporting the President's call for drug coverage for Medicare seniors, also supports intermediate and short-term steps. That is not to say we should not do anything. And that is why we are proposing the two new plans while we are proposing the Pharmacy-Plus waiver program, the discount card, and the low-income plan as well.

In terms of the question of CMS administering the Medigap option, I would say a couple of things. One, certainly, the Administration supports modernizing the fee-for-service cost-sharing struc-

ture, so that we may be able to even reduce the demand or need for supplemental coverage.

For example, we think that adding stop-loss coverage in a restructured cost-sharing package can be done in a way that may reduce the need to buy wrap-around coverage. Currently, there are several gaps. In addition to a lack of prescription drug coverage, you also have the lack of unlimited hospital days. You have got a cap on the number of hospital days a senior can get in any given year. You have increasing co-payments on both hospital days and nursing home care. In other words, you do have some financial disincentives for those seniors that face the highest health care costs. So one thing we are in agreement with is the need to re-look at the cost sharing in the government-run fee-for-service plan.

Second, we do have some concerns, however, about asking CMS, given all of their other responsibilities, to actually manage an additional set of responsibilities. And I am sure Dr. Young can also point out the other benefits offered by Medigap providers, whether they are discount cards or other services.

So on one hand, we are very supportive and want to work with this Committee and Congress to look at changing the fee-for-service cost-sharing structure, especially the addition of catastrophic and stop-loss coverage. But, on the other hand, we do have some concerns about asking CMS to take on those additional responsibilities.

Mr. McCrery. Madam Chair, if Dr. Young could respond?

Dr. Young. Yes. The figure that has been used, that was in the GAO testimony as well, Medicare's administrative cost—3 percent—is a very misleading figure. Those are the direct costs at the Health Care Financing Administration and to contractors. It does not include any of the costs of the tax system to collect premiums and to collect information.

Many of Medicare's costs in fact are passed on to its insurance carriers, through requirements for beneficiary education that the Medicare program does not carry out. So there are many things built into the government overhead and cost that do not show up in that 3-percent figure.

In addition, the market does do things that the government does not do. Bobby touched on a couple of them, in terms of education, in terms of drug discounts, in terms of services. So it is apples and oranges.

There is a third factor in there, and we are not any happier about it than Mr. Stark. But that is a 2- or 3-percent State premium tax that we have to pay in order to do business in every State. And if you can help us out with that, we would be grateful.

Mr. McCrery. Thank you.

Chairman Johnson. Thank you, Mr. McCrery. Mr. Stark.

Mr. Stark. Well, I am just going to raise a couple of issues here that I cannot quite make jibe, and I do not know if it is Mr. Jindal or Dr. Young who can answer them. But in the President's budget he talks about that his plans will improve by offering a prescription drug benefit to protect against catastrophic illness, and at a lower premium cost than the most popular Medigap plans today. Those are "C" and "F," I believe; and those average costs are about 1,100 and 1,200 bucks. The drug benefit plans run 1,700, so somewhere

in there, there is 600 bucks for drugs. There may be some travel stuff, but I do not think that amounts to a hill of beans.

What I cannot get to is, unless you are really going to deny people a lot of coverage, when you say first dollar, if you are really going to say they have got to be a couple of thousand bucks out-of-pocket, which I do not think we want to do, I think there is evidence—and maybe Mr. Scanlon and Dr. Young and Ms. Weiss would agree—that you get as much reduction of utilization for a $10 co-pay as you do for a major 20-percent co-pay; that the minimal dollar amount—and I know that Kaiser has found this—is absolutely as effective as a higher-dollar one in keeping people from carelessly using medical services. And I would hope we would keep that in mind. There is no sense punishing them. If we can get them to not abuse it for 10 bucks, let us leave it at that; rather than a higher amount.

But what I cannot get together here is how you are going to provide what, as I read your plan, is basically the same drug benefit that is currently in "J," and maybe in "A" and "I." So either you have got to have a phenomenally high premium, or you are just wild about how much money you are going to save by cutting back first-dollar coverage.

And it would help if you, in cooperation perhaps with Dr. Young's group—because we will not be able to set the price for this. This is whatever the insurance company is going to set. And if nobody buys it—because they are sure as hell not buying the drug benefits today. Why would they buy a policy with no first-dollar coverage and no better drug benefit? I cannot make that fit.

And I think that perhaps—and let me just throw out an idea, and then I will shut up—the possibility has occurred to me that I have no idea what this would cost. But because I do not want to fight with the private insurers, because then we would not get anything passed, for now, what if we said: Let us go back to the good old days of a catastrophic bill, a Federally administered catastrophic bill that would be universal community rate. Let us say we would pick up everything over two or three grand out-of-pocket. That would cut the risk, the long-term risk, for Dr. Young's Members dramatically. Let them fuss about first-dollar coverage then. And to show that we would let the private market help, we would let Dr. Young's companies, basically, sell that. The Federal government, in effect, would sell reinsurance. So you could tack that into your policies. We would underwrite it, as a reinsurer, as a Federal reinsurer, at whatever level we could afford. And then all of the policies would have some kind of an out-of-pocket cap, and it would include drugs.

And then, even for the people who choose to go without insurance—and as Dr. Young and Mr. Scanlon have said, the seniors know quickly; they do the arithmetic—then it is a question of the actuaries figuring out how to sort out those risks and charge a reasonable amount.

I think we could redesign this system, if the health insurers would work with us. And I do not think they are all jumping up and down to have that long-term liability, anyway. And that might be a different way to get to solving this problem. But I just do not think we can just move the pieces around on the chess board, be-

cause the costs are going to be the same, the instincts to purchase are going to be the same, the commissions are going to be the same.

I do not know how we get there from here. Maybe Mr. Jindal can tell me what I am missing. There cannot be that big a savings in the first-dollar coverage to pay for a major drug benefit. I mean, maybe there is, but I do not think Mr. Scanlon or I would agree with you. I would love to be convinced otherwise, but I do not see that. Can you help me with that?

Mr. JINDAL. Congressman, I thank you for the questions. With the Chair's permission, I would like to answer both of your questions.

First, the Administration has provided a couple of examples. We are obviously willing to work with you and the Members of the Committee on the details. We have provided a couple of examples of what Plans "K" and "L" could look like. And the independent actuaries at CMS, at the Department, have said that these would cost $500 less per year than current Medigap policies that cover drugs. In other words, making them comparable to what other Medigap policies are today that do not currently cover—

Mr. STARK. To "A" and "C." To bring them down to "A" and "C," yes.

Mr. JINDAL. That is correct. So you would bring it down in that ball park. And so you would be immediately offering a premium savings of $500 per year. You would do that. Not only would you save beneficiaries money, but also save the Medicare Program money, by doing modest cost sharing. We agree with you, it would not be a ridiculous amount of cost sharing.

Mr. STARK. But would that savings not all come out of their first-dollar coverage?

Mr. JINDAL. The premium reductions and the government savings would come down from the reduction of over-utilization.

Mr. STARK. And that is out-of-pocket to the beneficiaries, then. So I mean, it is pretty much—I mean, there may be some actuarial savings, but at the first-dollar level, I would guess that the premium reduction or increase is almost linear with the deductible for the first-dollar coverage.

Mr. JINDAL. Well, I think we are only talking about a $100 deductible to generate the $500.

Mr. STARK. But I am talking about the 20 percent and those. But go ahead. I am sorry.

Mr. JINDAL. Well, no, but I think you will see the savings. And I would certainly defer to the actuaries and others that would want to look at this. I think you will see the savings will come through utilization decreases. It would not be a cost shift. And I think you can see that by comparing the cost of employer-provided supplemental coverage with Medigap first-dollar provided coverage, if you look at utilization between those two populations.

And I think that Mr. Scanlon referred to the fact that even those employees with employer-provided coverage with very modest cost sharing and a structure similar to what we are describing here have lower utilization than those with first-dollar coverage.

And so, certainly, the concept that we are proposing and that we want to work with you on is how to drive down the over-utilization

and use those savings to benefit both beneficiaries and the Medicare program. And I think you have heard all of the witnesses today and you have heard Members on both sides agree that that would be a good thing, if we could accomplish that.

Mr. STARK. What are some of the areas? Where is the highest over-utilization? What is the area that is most abused?

Mr. JINDAL. Well, I think, again, if you look at the GAO work and the CBO work, what you will find is——

Mr. STARK. No, no, no, no, no. In Medicare, what is the area? What do us "old farts" do? Where do I go spend money that is the most abusive? Where do I waste the most money for Medicare? Is it getting proctoscopic examinations, buying medicine for strep throat? I mean, where do you find that us seniors abuse the system the most?

Mr. JINDAL. Well, Congressman, certainly, I am not going to make that characterization you made in terms of who is——

Mr. STARK. OK, but where?

Mr. JINDAL. Again, if you look at the CBO and GAO studies, and you look at where the utilization is higher for those with Medigap, versus those without Medigap——

Mr. STARK. But stop a minute. You are not hearing the question. What do the seniors buy with our taxpayer dollars? What is the highest abuse going to visit the doctor, going to the emergency room? What are the procedures that are the highest, the most abused, over-utilized?

Mr. JINDAL. I mean, I will not be able—I will defer to GAO, in terms of picking which single service is the most over-utilized. But again, if you look at the CBO and GAO studies, you see higher utilization across the board, in terms of both——

Mr. STARK. Would Mr. Scanlon know that?

Mr. SCANLON. I cannot give you a list of procedures specifically. I think that one of the things that we do ascertain from looking at the work that Dr. Wenberg does, in terms of the variation that exists across the country, is that all medical care is not necessarily optimal.

And that is part of this, I think. Because I think it is an issue that it is not necessarily a procedure, because with procedures often the needs criteria are more clearly defined. It can be chronic care for a condition, in which visits every 6 weeks could be adequate; but when there is no cost-sharing, there is no resistance on the part of the beneficiary or the provider to come back monthly. So it is something like that that may be affected by this kind of a change. That kind of a change would be benign.

Mr. STARK. But could we not also change that by restricting the providers in some cases, to say, in this case—if we could determine that—that every 2 weeks is too much, but perhaps every 4 weeks is correct?

What I am getting at is that sometimes I think that we blame the beneficiaries for things that they may not choose to do. And I am sure that most of us do not choose diagnostic tests, for instance. Most of them are not any fun. Possibly, a visit to the doctor; but often that takes getting on the bus, you know. I am not sure that it is entirely the patient. There may be some areas.

Mr. SCANLON. I agree with you, it is not entirely the patient. And we are not here to blame the patient. I think, though, that the idea that we could manage the program through utilization review is not feasible, given that we have got about 600 million claims for physician services in the course of a year.

We really need, I think, to enlist both beneficiaries and providers to be sensitive to cost. I mean, that is part of why cost sharing is in employer-based insurance, why it was originally put into Medicare. It is just that Medigap has taken away cost sharing from the Medicare Program. And having some cost sharing, I think, puts it more on the same basis as the way the rest of insurance is designed, and will provide some of that sensitivity to cost and will prompt questions about the value of services. That is what I think we can hope for at best.

Mr. STARK. Except that for the people in those plans, the difference between those—for example, with drugs and without drugs—is almost non-existent. The out-of-pocket costs—in other words, the Medigap with prescription drug and Medigap without prescription drug—the difference in the out-of-pocket costs for the beneficiaries is only 30 bucks a year. So that part of this first-dollar cost is the $1,000 premium they are paying. In other words, they are kind of pre-paying. They are funding their own medical savings account.

And depending on how far up you go, you are saying they are already paying $1,000; are you going to make them pay $5,000 before we clock in? I mean, how much more do you want to kick up their out-of-pocket costs? Or do you think if you made them pay the $1,000 on a per-doctor visit, they would spend less? That is possible. I do not know. Dr. Young?

Dr. YOUNG. I think this is a very important issue that deserves more attention and discussion than we have given it. As a physician, what concerns me is the research that has shown, yes, increasing out-of-pocket spending does indeed reduce utilization of services; but it could be unnecessary or necessary services.

Mr. STARK. Right.

Dr. YOUNG. So how do you know which one you are doing? And that may be a tool that is just a little too blunt, particularly for seniors, and frail seniors.

The other end of the research spectrum is on low-income people; and most of Medigap purchasers are low-income. And the Center, I think, has good data on that. It is that clearly, when you remove the affected insurance and simply look at service utilization by income, service utilization increases as income increases. And those at the low end report not having a regular physician, not getting the care that they need, delaying care. And so that very much concerns me, when we look at blunt data that says, "Here is how much money you can save." That may just be too blunt.

Mr. SCANLON. I think it should then concern all of the employers that are offering the same kinds of policies that we are talking about today in terms of restructured Medigap.

Dr. YOUNG. There are options that can be considered, and I think they should be when it is time to do a comprehensive reform. An option that looks at payment from a deductible may have a different effect than one that looks at copayments. An option that

looks at copayments through increased cost sharing will have huge administrative costs to it. So as the time comes to look at a comprehensive reform and a comprehensive set of packages, we are very interested in taking you up on your offer and discussing these things with you and trying to identify the best approach. Our interest is in a product that Medicare beneficiaries want to buy.

Mr. JINDAL. And if I could just add one final thing—and I know others may have other questions—I do think it is important to note that it is possible to decrease over-utilization without negatively impacting beneficiaries' health. And the choice is not either first-dollar coverage, or under-utilization. I do think there is a middle road. And we would be happy to work with the Members of the Committee.

I know there have been studies looking at self-reported health status and others. I think as long as the cost sharing is modest and reasonable and there are reasonable protections and out-of-pocket exposure, there is a way to, as Bill has mentioned, make beneficiaries aware of the cost of additional services without, as the Congressman has suggested, giving them false incentives to under-utilize care.

So I do not want to leave the Committee with the impression that the choice is either first-dollar coverage and over-utilization, or under-utilization. We do think there are moderate policies that can balance both of those competing goals, and do so better than we are doing so today.

Ms. WEISS. I also just want to reiterate that we would again recommend considering moving Medigap into Medicare and looking at the first-dollar coverage issue with maybe a modest co-pay or a modest premium—with the emphasis on "modest." There are multiple benefits to doing this. Again, we could talk about spreading risk throughout the entire Medicare population.

But again, two other key issues, one which I mentioned in the testimony: Currently, there are a number of States that do not provide Medigap coverage to people who are under 65 with disabilities. And the second point is that, depending on where you live, that determines how affordable your Medigap coverage is. States that have community rating provide the same cost to each person who enrolls, no matter what their age or when they buy the policy. However, most States have moved toward attained age rating. And while it may be a cheaper policy at the time you buy it when you are 65, as you age the costs go up, and it becomes more unaffordable at the very time when people have less money to spend. So again, I would reiterate looking at the option of moving it into Medicare.

Mr. STARK. The Chair is going to indulge me with one more question. Dr. Young, think about this. You cannot answer it here. But if we were to follow Ms. Weiss' idea, or even my idea of Federalizing Medigap, in effect, or some of it, what portions of the risk exposure—it is my understanding there are only five or six underwriters of Medigap left, anyway. That is close; isn't it?

Dr. YOUNG. Now you are talking about the overall risk exposure, in terms of services?

Mr. STARK. No, I am talking about—there are only four or five insurance companies left writing Medigap, as far as I know. Maybe there are a few more.

Dr. YOUNG. Oh, there are well over a 100 different insurance companies that sell this product.

Mr. STARK. There are?

Dr. YOUNG. Yes.

Mr. STARK. OK.

Dr. YOUNG. A large number of them.

Mr. STARK. The question is, if we were going to pick and choose, if we were going to Federalize a portion of the risk that they are now insuring through this variety of Medigap plans, what are the most profitable segments that your guys would like to keep, and what would you like to get rid of? In other words, I am sure the long-term liability you would love to get rid of, right?

Dr. YOUNG. Well, there are a lot of things we would like to get rid of.

Mr. STARK. No, I am serious. I am serious. I mean, that is the risky part.

Dr. YOUNG. Yes. I mean, the bottom line is what I said earlier. We would like to keep the piece the beneficiaries love. And I must say that one thing that is the highest on their list is they like the certainty of knowing what their out-of-pocket spending is going to be.

My mother, who could easily self-insure—and we have had this conversation many times, and I have concluded she is right—she loves her Medigap. Because she knows what her expense is going to be every single month.

And we forget in these conversations that Medigap is insurance. When the year begins, she does not know if she is going to be hospitalized twice, or once, or no times. She does not know if something is going to come up that is going to require 10 or 20 doctor visits. So she is sharing the risk of that unknown as the year moves forward. So she has the certainty; she has the peace of mind. And she has absolutely convinced me this is a good deal for her.

Mr. STARK. Well, I think that it is a good deal for you guys, too. And you are getting $1,000 or $1,100 a year, on average, $1,158, for, on average, 1,369 bucks out. So you are clearing a couple of hundred bucks per policy, which is about what you ought to be making. It is that simple.

Dr. YOUNG. Well, I mean, we are not clearing that on the profit side. My Members would love to.

Mr. STARK. No, but you are on your loss ratio side, easily.

Dr. YOUNG. Oh, in terms of the overall administrative costs, including everything.

Mr. STARK. Yes. But that is your word. I mean, that goes all to your Membership fees. But my point is that you are trading dollars with your mother. You are saying, "Mom, instead of putting the $2,000 in the savings and loan, and drawing on that if you need it, you pay so many bucks a month for your Medigap policy, and it is going to work out." And on average—which is what you depend on—it does.

Now, I am just saying you ought to take the front end of that and take the $2,000 chunk, and let us take the high costs and the outliers. And we should figure out, because there is no sense fighting with your guys—There is a lot of administration, a lot of fees, a lot of claims for you to pay. Maybe you would rather take the high stuff. I do not know.

Dr. YOUNG. Well, the problem with that approach is, as you get a product you are selling that is less and less and less in value—that is, has less benefits in it—your fixed costs remain the same. So the share of the fixed costs grows. If you can spread those fixed costs across a larger benefit package, then everybody is better off because of that.

Chairman JOHNSON. Thank you.

Mr. STARK. Thank you, Madam Chairman.

Chairman JOHNSON. I would like to pursue the topics that my colleagues initiated. I let them go first because I know that it is late and the last date, and they have other obligations, and I know Mr. Stark is not feeling very well. But I do want to pursue a couple of things.

First of all, the RAND health experiment study that showed that individuals were just as likely to limit the use of highly effective care as less-effective care, also indicated that there was no overall effect on health for the average person. So I am not aware of any studies that indicate that first-dollar coverage erodes health.

Dr. YOUNG. That is a very good point. The problem with that is the kind of research that you need to do, if you were to prove that. Because a large amount of medicine, every-day medicine, does not have an effect on mortality or a measurable outcome. It has an effect on activities of daily living; it has an effect on peace of mind; it reduces pain.

Chairman JOHNSON. But for example, Dr. Young, though, would it not be quite easy to look at Medicare participants who cannot afford Medigap? Those are the ones, frankly, I am most concerned about. The other group are Medicare recipients who can afford Medigap. Because you have two groups with exactly the same coverage; one of whom has first-dollar responsibilities, and one of whom does not. I mean, are we aware of any difference in health outcomes in those two groups?

Dr. YOUNG. As far as I know—and Bill can comment on this—we are not aware of it on either end of the spectrum, because it is such a difficult issue to measure. But we will see if he has some insights.

Mr. SCANLON. No, I am afraid I do not. I do not think we have good health status measures. I agree that we do not have comprehensive measures, and it is difficult to deal with. But at the same time, I think that there are discretionary services that people, when they are sensitive to costs, will forego. We have got to design cost sharing in ways that try to avoid people foregoing important services.

Chairman JOHNSON. I appreciate that.

Mr. SCANLON. Like hospitalization.

Chairman JOHNSON. I appreciate that, and I am not proposing that the answer is necessarily that we have no exceptions to the exposure of deductible. But I think it is important to remember

that we have no evidence showing that seniors who have Medicare and no other coverage are in worse health.

Now, we do know we have to exclude prescription drugs because, of course, that is not part of Medicare. And that seniors who have Medigap coverage, without prescription drugs, have better health outcomes because they are not exposed to the deductible. See, there really is no evidence supporting this.

I understand that that means the reverse is not necessarily true. But the one piece of evidence that we clearly do have is that the people who have first-dollar responsibility use fewer services. Though, we do not know that that necessarily results in poorer health outcomes. Now, logic would dictate that we have an interest in those people using preventive services.

And so we could use coverage as an incentive. We have never done that for any groups; where services are singled out as having no copayment, and therefore in a sense focusing on them and providing some kind of incentive to use them. And so, personally, I think that is philosophically a worthy thing to do.

I did want to get clearly on the board that one of the reasons the Committee is compelled to look at prohibiting 80 percent of first-dollar coverage, or 100 percent of first-dollar coverage, is because there is increased evidence that these people use more services, pushing premiums up for existing seniors and pushing taxpayer costs up. This money could be better utilized.

Now, I want to ask two sort of basic questions about the Administration's proposal. Are you proposing these two plans, and eliminating all other Medigap policies? Or are you proposing these two as additional Medigap policies?

Mr. JINDAL. I think that we absolutely are proposing these as additions to existing policies. So we are not trying to take away anything from seniors, or deprive them of options they have today.

I also want to absolutely agree with your earlier remarks. When you look at not only the RAND study, but other self-reported studies, you are right that seniors do not report a decrease in self-reported health status, as well. And I think that, from one of the previous questions, it is true that when you look at employer-provided coverage, either retiree or pre-retiree coverage, outside of this market, I am not aware of another market where you have got first-dollar coverage without some kind of coordination of care, without some kind of examination of utilization.

Clearly, what this Congress, what you have done through creating additional options for seniors, and in private plans, is you have allowed them to buy down—meaning Medicare+Choice and other plans—you have allowed them to buy down their cost sharing, reduce their cost sharing, but to do so in an integrated plan that also coordinates their overall care.

Chairman JOHNSON. Now, if these are options, why would you not be concerned about adverse selection? If I were a senior, for just 50 percent of Medicare cost sharing, that is 50 percent of the Part B deductible, really—no, you are not going to cover the Part B deductible.

Mr. JINDAL. That is correct.

Chairman JOHNSON. But then, your copayments for doctors' visits and things like that would be 10 percent, instead of 20 percent,

right? You know, for really a rather modest first-dollar responsibility, because you are proposing that you would cover the co-insurance in long-term hospital stays.

Mr. JINDAL. That is correct.

Chairman JOHNSON. Which has always been a big problem. And also, in nursing home? The variations in nursing home deductibles?

Mr. JINDAL. That is correct.

Chairman JOHNSON. So really, for the $100 deductible in Part B, and 50 percent less exposure in the co-insurance area, you are going to provide a $4,000 limit on out-of-pocket expenses, and 50 percent of all drug costs up to $6,000. Now, that seems to be an awful lot to be paying for, with just this change in the deductible. And you say this will be a lower premium than current Medigap policies.

Now, what do you think the premium is going to be? And what would be the difference between the premium for, say, your two proposals?

Mr. JINDAL. Well, first of all, we think the premium will be $500 or less than what it costs currently for Plans "H" and "J." So it would be competitive with what seniors currently pay for Medigap without drug coverage. So you are absolutely right. We look at this as a great deal for seniors, but also a good deal for the Medicare program, as well.

Seniors will be able to reduce their out-of-pocket spending on premiums by $500. The Medicare Program will save well over a billion dollars. Plus, you have over 700,000 seniors who do not have drug coverage today, who would get drug coverage through these options. So we absolutely agree with you.

Chairman JOHNSON. But now, just a little bit slower. You say this would be $500 less. And yet, instead of providing 50 percent of drug costs, for a maximum of up to $3,000, this would go up to $6,000. So you are getting, you know, $1,500 more in drug costs, and the $5,000 limit on out-of-pocket expenditures under the rest of the plan. And you can do that for $500 less, just because of the copayment changes?

Mr. JINDAL. That is right. Well, and the drug benefit is actually identical to what is contained in Plans "H" and "J" now. And that helps to address part of your concerns about adverse selection. By not varying the drug benefit, but by using the changes in over-utilization to help pay for that, that helps to make the plan more affordable, and increase the number of seniors with drug coverage.

Now, we do not look at this as a comprehensive solution. We look at this as a first step that we would like to work with you and other Members to help increase the numbers with drug coverage and reduce the cost for seniors.

Chairman JOHNSON. And what would be the premium on the one that covers 75 percent of cost sharing, and a $2,000 limit on out-of-pocket expenditures, but only covers 50 percent of drugs, up to $2,500?

Mr. JINDAL. And again, it would be roughly $500 less than Plan "H."

Chairman JOHNSON. Both of them have roughly the same premium?

Mr. JINDAL. That's right—Well, no, they are $500 versus their counterparts. So Plan "K" would be roughly $500 less than Plan "J," Plan "L" would be roughly $500 less than Plan "H," in terms of what seniors can pay today. And obviously, as you heard, there is a variation across States and across plans, but it would be roughly $500 less than their counterparts today.

Chairman JOHNSON. That is very interesting. Do you have any comment on that, Mr. Scanlon?

Mr. SCANLON. I cannot comment in terms of the amounts of the premiums. We did not have the details before today. And also, we need to think about talking with actuaries about this.

I do think the issue that you raise of selection is a very important one here. One of the things that is true about current Medigap plans is that beneficiaries have an open enrollment period in the first 6 months in which they are Medicare eligible. And then there are certain enrollment rights when people leave Medicare+Choice plans or when their employer coverage is dropped. What the terms would be, in terms of beneficiaries being able to sign up for new plans, would be critical in affecting selection.

I would surmise that perhaps some of the low use of Medigap drug coverage today is the fact that most seniors became 65 when drugs were not such an important issue. I mean, if you think about it, our focus on drugs as both expensive and as having incredible therapeutic value has been a relatively recent phenomenon. People that are turning 65 today may have a very different perspective on wanting to buy drug coverage than those that turned 65 in the early nineties or in the eighties.

Chairman JOHNSON. Thank you. I was not aware that Medigap was quite so rigid as I heard from your description. You can change Medigap plans from one to another now, although sometimes you will have to pay more because you get medically underwritten, right?

Mr. SCANLON. That is correct. I mean, generally, plans are available without underwriting when there is no drug coverage involved. But when drug coverage is involved, it is very hard to find a plan without underwriting.

Chairman JOHNSON. And Mr. Jindal, would there be underwriting for eligibility for Plan "K" and Plan "L"?

Mr. JINDAL. The protections we envision will be those similar to what exists today, in terms of the 6-month enrollment. So that seniors would have a chance to sign up 6 months after they become eligible for the program, when they turn 65.

And given those assumptions, that is the basis on which the actuaries assumed you would have one and a half million beneficiaries choose these plans and, as a conservative estimate, you would save the program over a billion dollars, but you would also save beneficiaries $500 a year in premiums. So again, that is why we described it as a "win-win" for the program and for beneficiaries.

Chairman JOHNSON. And would you envision opening Plan "K" and Plan "L" only to new retirees? Or would there be a one-time opportunity for all Medigap participants to change into those plans?

Mr. JINDAL. I think we could certainly—I think we would be open to that one-time opportunity for existing Medicare beneficiaries, as well; not just those turning 65.

Chairman JOHNSON. Can you also look at, as you estimate—and this is all of you, because I am sure all of you in your own bailiwicks will be looking at this. But I think we ought to begin looking at opening it every 5 years. You know, the rigidity of the plans does not seem to be in the interests of seniors, and not necessarily in the interests of government.

Now, that would be particularly true if we also eliminated the absolute first-dollar coverage of all of the Medigap plans. Anyone who can afford to buy a Medigap plan can actually afford some level of first-dollar responsibility. And so, if there were some first-dollar responsibility across the board, you might then be able to open these bigger plans more frequently that have more catastrophic coverage aspects to them, both in the catastrophic coverage for Medicare and in the higher drug assistance.

Dr. YOUNG. The problem that you will run into, though, very quickly, if you opened it up, let's say, every 5 years to anybody who wanted it, is that the healthy people at age 65 would say, "I am going to wait."

Chairman JOHNSON. I appreciate that. Yes, I appreciate that problem. But it depends on how expensive they are. When you say they are $500 less than the current plans, those are the most expensive current plans. So that is a problem.

Dr. YOUNG. Yes. And then that just drives up the premiums for everybody else, when the people do select like that.

Chairman JOHNSON. Now, in terms of——

Mr. CARDIN. Would the Chairman yield on that point?

Chairman JOHNSON. Yes.

Mr. CARDIN. Just on that point.

Chairman JOHNSON. Let me welcome Ben Cardin. He is not on the Subcommittee, but he often joins us. It is nice to have you here.

Mr. CARDIN. Thank you. Thank you, Madam Chair.

What I do not understand is, if there has been continuous coverage, why do we then require an individual who wants to join a Medigap plan that has prescription drug coverage to be subjected to medical underwriting? For example, if a person has been insured by an HMO, and that HMO pulls out of the market—which has happened in my State—why should that individual not be able to join one of the Medigap plans at that time, without the concern of medical underwriting?

Dr. YOUNG. They are. Under current law, they are allowed to. There is a special election period when an HMO goes out of business and leaves the market that they are allowed to, under current law.

Mr. CARDIN. For how long?

Dr. YOUNG. What is the time?

Mr. CARDIN. Yes.

Dr. YOUNG. The window that they have that they can make that election?

Chairman JOHNSON. I believe it is 2 months.

Dr. YOUNG. Yes, it is 63 days.

Chairman JOHNSON. Yes.

Mr. CARDIN. Now, that also applies to the prescription drug plans?

Dr. YOUNG. No. No, it only applies to the basic Medigap.

Mr. CARDIN. Why does it not apply? My question dealt with prescription drug plans.

Dr. YOUNG. OK, now I understand your question.

Mr. CARDIN. My question is, why does that not apply to the prescription drug plans?

Dr. YOUNG. Yes. And again, because of, I think, the concern of the costs and the risks.

Mr. CARDIN. I guess I do not understand that, Dr. Young. If the person had continuous coverage, why would you be concerned about adverse risk selection? The person is just going from one plan to another. This is the same situation we do for private insurance, basically.

Dr. YOUNG. It is if people make the choice to move for that very purpose. What we have seen, for example, in the Medicare Choice program is that people have come into Plan A with a $1,000 benefit; used up their drugs; left; gone to another one; and received drugs again. So beneficiaries will do those kinds of things.

Mr. CARDIN. Well, no, the scenario I am giving you is a person who is in an HMO, a senior who is in an HMO, expected to stay in that HMO. The HMO has left the market. The HMO had prescription drug coverage. The individual, if the individual comes from Maryland, has no HMO that that person could enter into any longer and get prescription drug coverage. The senior made a decision at 65 to go into the Medicare+Choice HMO to have prescription drug coverage and forego the opportunity to get a Medigap plan with prescription drug coverage. I guess I do not understand the logic as to why we would want to restrict a senior——

Chairman JOHNSON. If the gentleman will yield——

Mr. CARDIN. Who has had continuous coverage.

Chairman JOHNSON. If the gentleman will yield, I think the point he is making is really very well taken. If your plan leaves the market, why can you not buy a comparable plan? Now, if you had not been paying for one with prescription drugs, I can see the problem. But if you have been paying a higher premium for prescription drugs, why could there not be that continuity, so you would have access to one with prescription drugs?

If you were in an Medicare+Choice plan that did not have prescription drugs, then your only choices would be other plans that did not have prescription drugs. But I find it hard to believe that we cannot structure that kind of arrangement.

That does not solve the other problem that we are having, which is when Medicare+Choice plans do not leave the market, but change their benefits so dramatically that people are not getting the best value for their dollar, and you decide to move into another Medigap plan. There are some circumstances in which you can do that, but I do think we need to clarify those situations.

Dr. YOUNG. I think your points are well taken. And it is important to remember, as Mr. Scanlon told us a bit ago, that the rules and the policies that are currently in place for Medigap came about in 1990 or 1992 when they were implemented. The world has changed dramatically since that time. The Medigap structure, in

terms of adding a couple of new benefits, has changed dramatically since that time.

And as you consider Medicare reform, as I said in my testimony, that will be the time to look at all of these issues, revisit them all, and see what are the best policies that work for the beneficiaries. So we are dealing today in a world and a set of policies that are now 12 years old.

Chairman JOHNSON. Well, I do appreciate the testimony of the panel. And I appreciate, Ms. Weiss, your comment that seniors are adverse to change, and need security. That is why I was so interested in whether Mr. Jindal's proposals were as a substitute for all of the existing Medigap proposals, or simply an addition.

And actually, let me see if my colleague, Mr. Cardin, has any further questions.

It is very interesting how the literature has come together—and I do not want this point missed—to indicate that first-dollar responsibility is responsible. And I think we do need to take that into account, especially now that we have some very, very powerful information as to how that money could be reused to expand benefits.

So I thank you for the thinking that you have done on this, Mr. Jindal. And I ask all of you now to go back and run numbers on his ideas, and run numbers on some of the other ideas that have come up, like holding harmless preventive health care, which the administration has talked about but which is not in this particular plan. Because I think we need to see what are the outlines of the most progressive plans that are still different from the Medicare Choice option, which will have a better ability to provide product, disease management, case management of very ill people, and some other things that also are important for us to better understand.

Thank you very much for your attendance this afternoon. I appreciate your input, and look forward to working with you. Thank you.

Mr. JINDAL. Thank you, Madam Chairman.

Mr. SCANLON. Thank you.

Dr. YOUNG. Thank you.

[Whereupon, at 3:43 p.m., the hearing was adjourned.]

[Questions submitted from Mr. Shaw to Mr. Jindal, and his responses follow:]

U.S. Department of Health and Human Services
Washington, DC 20201

Question 1:

The Congressional Budget Office (C.B.O.) indicated that elimination of first-dollar coverage would save approximately $1 billion but did not consider the impact of such a policy change on states that mandate first-dollar coverage. Would you be willing to work with Congress and the C.B.O. in order to quantify the impact on states which have this mandate?

Answer:

Thank you for giving me the opportunity to clear up any confusion surrounding our Medigap proposals. The Administration is proposing to increase the choices available to Medicare beneficiaries and would not eliminate any existing policies. Specifically, we propose immediate action to add two new Medigap policies to the array of choices available to seniors to purchase Medicare supplemental insurance. We have labeled these new policies "K" and "L" because they would be offered in addition to current standardized policies labeled "A" through "J." These new policies would combine limited cost-sharing with stop-loss protection for Medicare covered

services and a prescription drug benefit. Again, they would not replace existing Medigap policies but rather provide additional options for seniors.

Currently, seniors can choose between any of the ten standardized policies as well as two high-deductible options. It is true that virtually all states require new Medigap policies to conform to these standards, and that most of the current policies—particularly the most popular ones—include first-dollar coverage. We believe it would not be difficult to add these two new options, however, in the same way that the Balanced Budget Act added the high-deductible options, and want to work with Congress and the state insurance commissioners to make this a reality. This would also give seniors a choice that falls between getting first-dollar coverage for hospital costs and doctor visits—but with drug coverage available only as an expensive add-on—and having to pay all costs below the high-deductible level. While seniors with any of these existing Medigap policies would have a one-time opportunity to switch to one of the new policies, no beneficiary who was happy with their current policy would be required to switch.

As for the estimate of savings prepared by the Congressional Budget Office, our understanding is that their analysis of the President's budget proposals assumed there would be new Medigap policies—ones that would not provide first-dollar coverage—and did not assume all existing first-dollar coverage would be eliminated. Apparently they also assumed a benefit design for these new policies that is different from the one described in my testimony. Nevertheless it is important to point out that the administration also projected 10-year savings of over $1 billion just by offering these two new options.

Question 2:

American Viewpoint conducted a poll and listening groups on behalf of Blue Cross Blue Shield Association asking seniors about their satisfaction with their Medigap policy. CMS also has similar data showing an overwhelming number of Medigap policy holders (between 80% to 90% based on various estimates) are "very satisfied" with their Medigap policy. In the Administration's proposal to eliminate first-dollar coverage, have you considered incorporating a transition period in order to gradually phase out this feature of Medigap policies?

Answer:

Again I want to emphasize that the administration is proposing to expand choices available to seniors, not to limit them. In designing this proposal we were very much aware of the data you cite and we know that many beneficiaries are satisfied with their current supplemental coverage and do not want to change. Others may prefer to purchase policies that include limited cost sharing but have lower premiums and include prescription drug coverage. The new policies proposed by the administration would give them this chance. We estimate that as many as 1.5 million beneficiaries would welcome such an opportunity—and that nearly half of them (about 700,000) would be beneficiaries who do not have drug coverage now. Moreover, we can achieve this significant increase in drug coverage among seniors right away, not several years down the road, while saving money for beneficiaries and the Medicare Program. It is interesting to note that the same poll you cite found that about one-third of Medigap policy-holders would favor a proposal that required Medigap plans to have a modest deductible and some payments for doctor visits and hospital stays—even without the offer of drug coverage. Thus, our proposal—which would offer such coverage but not require it—might attract more enrollees than we project.

Question 3:

Have you considered implementing preemptive initiatives to minimize disruption or confusion that the administration proposal might cause for Medigap policy holders in Florida?

Answer:

I wish to emphasize that our proposal does not entail disruption of the current Medigap market. Medigap policy holders should not experience any disruption because of the availability of new supplemental policy options. Since the OBRA 1990 Medigap reforms standardized Medigap benefit designs, the options offered to beneficiaries have hardly changed while medical practice has evolved and policy premiums have continued to rise. We believe that many beneficiaries will welcome the chance to purchase more affordable supplemental policies with limited cost sharing, protection against high out of pocket costs, and prescription drug coverage. On the other hand, seniors who are happy with their current Medigap policies will be able to keep them as long as they like. The Administration is committed to increasing beneficiary choice and keeping seniors fully informed about all of the choices available to them, including the availability of local Medicare+Choice plans as well as Medicare supplemental policies.

[A submission for the record follows:]

Statement of the National Association of Health Underwriters, Arlington, Virginia

The National Association of Health Underwriters (NAHU) is an organization of over 17,000 insurance professionals specializing in the sale and service of health insurance and related products. Many of our Members who specialize in the senior market regularly counsel and work with Medicare beneficiaries on Medicare, Medigap, and Medicare+Choice options as well as other types of products. We are pleased to offer comments and suggestions regarding the current options and enrollment procedures for supplemental health insurance coverage for Medicare beneficiaries.

NAHU believes that there are a number of inherent problems within the Medicare program that can only be addressed through comprehensive Medicare reform. The current Medicare programs A and B present an antiquated approach to the financing of health care reminiscent 1960, when the greatest fear for most seniors was an extended hospital stay. Now, with many services provided on an outpatient basis and the availability of stronger and more effective prescription drugs, many beneficiaries are able to avoid hospitalization. Due to the advances in medical treatments, the level of coverage provided under traditional Medicare is inadequate protection for most seniors. The best solution to the problem would be to combine Parts A and B into one comprehensive program, with a mid-range combined deductible and adequate protection against catastrophic risk, including the cost of prescription drugs. This would require Medicare supplemental coverage as we know it to change dramatically to conform to the new comprehensive form of Medicare.

Given the current political climate, however, it appears that it may be necessary to achieve Medicare reform on an incremental basis. If we presume that the basic Medicare program is not going to change dramatically in the immediate future, the first task will be to make sure that consumers have a variety of choices to allow them to select the type of plan most suitable for their personal situation. The first step will be to ensure that Medicare+Choice plans and Medicare supplement providers have incentives to participate in health plans for Medicare beneficiaries. It is essential that the current regulatory requirements for Medicare+Choice plans be eased and that they be compensated fairly.

Although today's hearing concerns Medigap coverage, the current instability in the Medicare+Choice program obviously has a significant impact on increasing demand for Medigap coverage on a guaranteed issue basis. This increased demand may significantly alter both the availability and the cost of Medigap policies. Action by Congress to address this urgent situation will only have a positive impact on beneficiaries purchasing Medigap policies.

Our Members report the following regarding market experience and beneficiary preferences concerning Medigap policies:

- The most popular benefit is coverage of the Part A deductible. Coverage of the Part B deductible is sometimes purchased, but often because some other benefit in the plan is desired.
- The skilled nursing benefit isn't used often because of the difficulty in meeting the requirements for skilled care due to the mandatory 3-day hospital requirement, and because most care quickly falls into a custodial category not covered by Medicare.
- Coverage of Part B excess charges is becoming more and more important, especially in rural areas where physicians may not feel compelled to accept Medicare assignment. In the absence of any stop-loss provision being added to the basic Medicare program, coverage of these excess charges should remain available.
- The most popular plans sold by our members are C, F, H and I. Although some employers offer this benefit plan for their retirees, very few people want to pay the premium associated with plan J.
- The benefits beneficiaries request most often, that are not currently covered by Medigap, are for coverage of dental care, vision services, hearing aids, and of course, prescription drugs.

BENEFICIARY REACTION TO MEDICARE

Based on what Medicare beneficiaries tell our Members, the most significant problem facing them today is the **cost** of health care. Many Americans approaching retirement age believe that when they become eligible for Medicare, all of their health care needs should and will be taken care of. Their first step into the Medicare maze

comes when they discover that they must purchase Part B to cover outpatient and other physician care. Many of these beneficiaries believe that Part B is a supplement, especially since the Medicare supplements are alpha labeled, and they don't understand that they will still have significant financial exposure for the cost of their medical care.

Often beneficiaries first become aware of the gaps in coverage after they have passed open enrollment for Medigap. Unfortunately, by that time some have developed health problems, limiting or eliminating their choices for supplemental coverage. Having been participants in low co-pay drug cards as employees for many years, they are amazed to find out how much coverage for prescription drugs will cost them, if it is available at all, and many of them seek supplemental coverage for prescription drugs at this time.

They are even more amazed to learn the extent of the other medical services not covered under the traditional Medicare program. Many of these same individuals who may have sought supplemental coverage in order to secure insurance for prescription drugs end up buying plan C or F (which doesn't cover outpatient prescription drugs) primarily to cover hospital and physician charges not covered by the Medicare program. Since the benefit under a Medigap policy that includes limited coverage for prescription drugs is often equal to or less than the extra premium charged, many beneficiaries choose not to purchase prescription drug coverage. Many of these Medicare beneficiaries have low incomes limited to little beyond their Social Security benefit, but for a variety of reasons they may not be eligible for Medicaid or other low-income programs. Additionally, the Medicare+Choice plans, which they might have been able to afford, may no longer be available in their area.

RECOMMENDATIONS

So how could Medigap be structured to make it more meaningful as well as more **affordable?** Again, in the absence of basic in-depth changes to the Medicare program, our first recommendation would be that **no Medigap plan subsidize the Part B deductible**. There are numerous statistics that show that individuals with Medigap coverage utilize medical services at a significantly higher rate than Medicare beneficiaries without supplemental coverage. Their utilization rate is also higher than that of retirees with supplemental coverage through their former employers. We believe the reason for this is that there is typically some cost sharing for beneficiaries covered under employer plans, and that plan utilization can be safely reduced if there is some financial incentive, however small, that causes a person to think before seeking medical care for even the most minor illnesses.

In terms of **prescription drug coverage, we are very skeptical of any sort of mandate on Medigap plans to provide drug coverage**. Insurance carriers report that plan utilization is significantly higher on Medigap plans H, I and J, and, based on their experience, they have consistently maintained that drug-only policies or mandatory drug coverage on all policies is simply not an insurable risk. Although pharmacy benefit managers have expressed interest in being providers in a Medicare prescription drug program, they have not indicated a desire to take on all of the risk for the program.

While it may seem an easy and simple solution to the problem of providing a drug benefit for seniors, in the absence of overall Medicare reform, we see no way to magically produce a drug benefit for seniors by requiring that it be offered by Medigap carriers. If it is offered as a mandate on all plans, the cost of coverage will increase beyond what is affordable for many seniors. If it is offered voluntarily, the plans with drug coverage will be selected by those that need them most, while others will continue on as they are now. This will simply exacerbate the already serious problem of the cost of coverage by increasing anti-selection causing carriers to leave the Medigap market, leaving even fewer choices for seniors than they have today.

On a positive note, some insurance carriers, as well as some of our member agents, routinely provide Medicare beneficiaries with a **prescription drug discount card**, often at no cost to the beneficiary. Some Blue Cross organizations have begun to extend the discounts they have negotiated through the pharmacy benefit managers, with whom they contract for their under-65 insureds, to their Medicare Supplement policyholders. ***This allows policyholders to purchase their outpatient prescription drugs at significantly discounted rates, as much as 15 to 30%, even though outpatient drugs are not specifically covered by their Medigap policy***. This provides no risk for the insurance carrier, but is an excellent way for beneficiaries to reduce their cost by using their numbers to negotiate discounts. For this reason, we're extremely pleased with the Administration's proposal for a prescription drug discount program for Medicare beneficiaries. We believe the discounts that could be provided by these programs will be greater than the Administration's estimates, based on the experience of employer plans in the under-65

market, and that beneficiaries would greatly value the assistance the discounts would provide. As an interim solution in the absence of overall Medicare reform, the discounts will bring a valuable price break to Medicare beneficiaries at all income levels.

NAHU also recommends that additional study be given to the very complicated coordination between COBRA and Medicare, and between individual health plans and Medicare. It is very difficult for beneficiaries, agents and employers to navigate through the landmines associated with these benefits. Many beneficiaries discover too late that they should have made different decisions when applying for Part B after they prematurely trigger Medigap open enrollment rights, or when they are forced to go without Part B for an extended period of time due to late enrollment time penalties.

Many others retain individual health insurance policies for years because they believe the policy will serve as a Medicare supplement, only to find that their individual policy will actually pay little beyond what Medicare pays due to language on guaranteed renewability found in HIPAA. This is not the fault of the carriers, agents or employers but rather the complexity of several overlapping Federal laws that don't coordinate adequately or provide for adequate notice to insureds of their rights and responsibilities.

Disabled Medicare beneficiaries need better access to Medigap coverage. Due to cost considerations, we are not suggesting that disabled beneficiaries have the same purchase rights and plans as those age 65, since doing so may mean increases to Medicare beneficiaries' already escalating Medicare supplement premiums. We do believe that creative options should be explored for extending coverage that won't increase costs for other beneficiaries, such as offering coverage for disabled beneficiaries through state high-risk pools.

Currently eight states allow disabled beneficiaries to purchase coverage through high-risk pools. This allows these less healthy individuals to be pooled with other individuals in the same category, provides a place to purchase supplemental coverage, and keeps the costs down in the regular Medigap pool. We've included a chart for members of the committee illustrating the type of supplemental coverage currently available through high-risk pools.

Medigap policies are highly valued by Medigap beneficiaries and provide a great sense of security for millions of Medicare beneficiaries. Although changes need to be made to Medigap coverage, it may be difficult to implement broad reform without knowledge of the end result of reforms in the Medicare program itself, and any changes undertaken should be done with careful consideration of any impact they may have on current market availability.

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HIGH-RISK POOLS THAT INCLUDE MEDICARE SUPPLEMENT

State	Is Medicare Disabled Covered?	Standardized Plans Offered?	If No Standardized Plans, What Is Offered?	Are Prescription Drugs Covered?
Alaska	Yes	Plans A & I. Medicare "carve-out" offered to those under age 65.		Yes
Minnesota	Yes	No	Two plans, Basic Plan and Extended Basic Plan.	Yes, but only from Extended Basic Plan.

HIGH-RISK POOLS THAT INCLUDE MEDICARE SUPPLEMENT—Continued

State	Is Medicare Disabled Covered?	Standardized Plans Offered?	If No Standardized Plans, What Is Offered?	Are Prescription Drugs Covered?
Mississippi	Yes	No	An individual under age 65 who becomes eligible for Medicare after purchasing a high-risk pool plan may keep the plan as a Medicare "carve-out."	Yes, prescription benefits are covered under the high-risk pool.
Montana	Yes	No	Medicare "carve-out" offered.	Yes
North Dakota	Yes	Plan F		No
Washington	Yes	No	Medicare "carve-out" offered.	Yes
Wisconsin	Yes	No	Individuals under age 65 are offered Medicare disability plan.	Yes
Wyoming	Yes	No	High-risk pool is secondary to Medicare.	Yes

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